## PORTER MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0035 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 8/18/2020 12:24 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 8/18/2020 Time: 12:24 pm use only Manually prepared cost report 2 [ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5. 1 ]Cost Report Status Γ 

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN
 11. Contractor's Column 1 is 4: Enter

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title Date 

			nue	AVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	10, 959	-78, 095	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	8, 916	113		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	) Total	0	19, 875	-77, 982	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

PLI	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTI FI CATI ON	DATA	Provi d	UEI CCIN.	15-0035	Period: From 01/01 To 12/31		Part I Date/Ti 8/18/20		pare
	1.00		2.00		3.00			4.00			
~	Hospital and Hospital Health Care Co										
0 0	Street: 85 EAST US HIGHWAY 6 City: VALPARAISO	PO Bo: State		Zip Cod	D. 14203	Coup	ty: PORTER				1
5		Component		CCN	CBSA			Payme	ent Syst	em (P,	
				Number	Number		Certified	I <u> </u>	, 0, or	N)	
				0.00	0.05		<b>F</b> 00	V	XVIII		-
	Hospital and Hospital-Based Componen	<u>1.00</u> t Identificati		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
0		PORTER MEMORIA		150035	23844	1	07/01/196	6 N	Р	0	3
	•	HOSPI TAL	-							_	
0	Subprovider - IPF			457005		-	01 (01 (000)				4
0 0	Subprovider - IRF Subprovider - (Other)	PORTER REHAB U		15T035	23844	5	01/01/200	9 N	P	0	5
) )	Swing Beds - SNF										7
0	Swing Beds - NF										8
0	Hospital-Based SNF										9
00	Hospital-Based NF										10
00	Hospital-Based OLTC										11
00 00	Hospital-Based HHA Separately Certified ASC										12   13
	Hospi tal-Based Hospi ce										13
	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC							1			16
00	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18
50					1		From	1:	То	:	19
							1.00	C	2. (		
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2019	12/31/	/2019	20
JU	Type of Control (see instructions)						4				21
						1.00	2.0	5	3. (	00	1
	Inpatient PPS Information										
00	Does this facility qualify and is it disproportionate share hospital adju:					Y	N				22.
	§412.106? In column 1, enter "Y" for				·						
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" for										
01	Did this hospital receive interim un					Ν	N				22
	cost reporting period? Enter in colu the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or afte	er October 1.	(see instru	uctions)							
02	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of the										
าว	October 1. Did this bespital receive a geographi	i a radiacal fi -	ation from	urban +-		NI	NI				
03	Did this hospital receive a geographi rural as a result of the OMB standard					Ν	N		N		22
	adopted by CMS in FY2015? Enter in co	olumn 1, "Y" fe	or yes or "	'N" for r	10						
	for the portion of the cost reporting	g period prior	to October	⁻ 1. Ente							
	in column 2, "Y" for yes or "N" for i										
	reporting period occurring on or afte Does this hospital contain at least				is						
	counted in accordance with 42 CFR 41.										
00	yes or "N" for no.		11	and / 07			2				
00	Which method is used to determine Me below? In column 1, enter 1 if date of						3 N				23
	if date of discharge. Is the method (			2							
	reporting period different from the i	method used in	the prior	cost							
	reporting period? In column 2, ente	r "Y" for yes			toto	Out of	Out of	Mod: a-		thor	
			In-Stat Medicai			Out-of State		Medica HMO da		ther li cai d	
			paid da				Medi cai d	ua,	·	lays	
				unp	aid p		eligible				
			1.00	da	-	2 00	unpai d	E 00	,	. 00	-
00	If this provider is an IPPS hospital	enter the	1.00	2. 329	00 556	3.00	4.00	<u>5.00</u> 6,	900	00 238	24
	in-state Medicaid paid days in colum		1, 0	- '	555	JZ	55	υ,		200	24
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c										
		d days in colu									

SPI T	Financial Systems PORTER AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MEMORIAL H	Provider CC	N: 15-0035	Peri od:			eet S-2	2552·
-					From 01/0 To 12/3		Part I Date/T 8/18/2		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Me	ither di cai d days	
. 00	If this provider is an IRF, enter the in-state	1.00	2.00 10	3.00 0	4.00	5.00	159	6.00	25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
00					1.	Rural S 00		- Geogr 00	1
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. age) status	at the end	d of the cos		1			26.
. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
					Begi n 1.		Endi 2.		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date	es.	·						36
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH tran	sitional pa	ayment in	S	0			37
00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st	atus. Ifli	ne 37 is					38
	enter subsequent dates.				Y/		۲z		
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremer	ter in colum nts in	in		<u>2.</u> N		39
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			J	M	J	40
						V 1.00	XVIII 2.00	XI X 3.00	-
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	te share in	accordance	N	Y	N	45
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.					N	N	N	46
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	•		2		N N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (						56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	r yes or "N th of this Y", complet	" for no ir cost report e Worksheet	n column 1. ting period?	lf column Enter "Y				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	s as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes	s <u>, complete</u>	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	35 Worksh Lin		 Pass-T Qualifi Criteri	cation	
				1.00	2.	00	3.	00	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (see umn 1. If	column 1	N					60.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: com 01/01/2019 p 12/31/2019	Worksheet S-2 Part I Date/Time Pre	pared:
		Y/N	IME	Direct GME	IME	8/18/2020 12: Direct GME	24 pm
	1	1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	) O. OC	61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
01.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
2. 00 2. 01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instructior	ter (THC) into			62.0 62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	ictions)	N	63.0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	_
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
4.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64. C

	EX IDENTIFICATION DA	IA Provider (	Fr	riod: om 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 8/18/2020 12:	epared 24 pm
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	1
			Site			4
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	) 65 (
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by colume 2, column						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted FTEs in	Ratio (col. 1/	
			FTEs Nonprovider	Hospital	(col. 1 + col. 2))	
			Si te	2.00	3.00	-
Section 5504 of the ACA Current Y	/ear FTE Residents in	n Nonprovider Settin	1.00 asEffective fo	<u>2.00</u> r cost reporti	3.00 na periods	
beginning on or after July 1, 201 .00 Enter in column 1 the number of u		ry care resident	0.00	0.00	0.000000	) 66 (
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column 3	3 the ratio of	Unweighted FTEs Nonprovider Site	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	
				1.0	0 2.00 3.00	-
		IPE) or door it com	tain an LDE outra			70.0
Inpatient Psychiatric Facility PP						/0.
.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.					0	71.
<ul> <li>.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.</li> <li>.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)</li> </ul>	the facility have an prore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) program ye	DO4? Enter "Y" for y ility train residents )(D)? Enter "Y" for y	s in a new teach yes or "N" for n	i ng p.		
<ul> <li>.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.</li> <li>.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic</li> </ul>	the facility have ar efore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye y PPS mabilitation Facility	004? Enter "Y" for y llity train residents )(D)? Enter "Y" for y ear began during this	s in a new teach yes or "N" for n s cost reporting	i ng p.		75. (

Health Financial Systems PC	RTER MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	ON DATA	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 8/18/2020 12:	pared:
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter 81.00 Is this a LTCH co-located within another hospita "Y" for yes and "N" for no.	2			g period? Enter	N N	80. 00 81. 00
TEFRA Providers         85.00       Is this a new hospital under 42 CFR Section §413         86.00       Did this facility establish a new Other subprovidence of the providence of the pro	der (excluded				N	85. 00 86. 00
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" fo 87.00 Is this hospital an extended neoplastic disease 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for</pre>	care hospital	cl assi fi ed	under section		N	87.00
	110.			V 1.00	XI X 2.00	-
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpat	ient hosnital	services? F	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 [Is this hospital reimbursed for title V and/or X				N	N	91.00
full or in part? Enter "Y" for yes or "N" for no	in the appli	cable column				
92.00 Are title XIX NF patients occupying title XVIII instructions) Enter "Y" for yes or "N" for no in	the applicat	ole column.			N	92.00
93.00 Does this facility operate an ICF/IID facility f "Y" for yes or "N" for no in the applicable colu	imn.			N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter " applicable column.	Y" for yes, a	and "N" for n	o in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentag 96.00 Does title V or XIX reduce operating cost? Enter				0. 00 N	0. 00 N	95.00 96.00
<ul> <li>applicable column.</li> <li>97.00 If line 96 is "Y", enter the reduction percentag</li> <li>98.00 Does title V or XIX follow Medicare (title XVIII stepdown adjustments on Wkst. B, Pt. I, col. 25?</li> </ul>	) for the int	terns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
column 1 for title V, and in column 2 for title 98.01 Does title V or XIX follow Medicare (title XVIII C, Pt. I? Enter "Y" for yes or "N" for no in col	XIX. ) for the rep	porting of ch	arges on Wkst.	Y	Y	98. 01
<ul> <li>title XIX.</li> <li>98.02 Does title V or XIX follow Medicare (title XVIII bed costs on Wkst. D-1, Pt. IV, line 89? Enter "</li> </ul>				Y	Y	98. 02
<pre>for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII reimbursed 101% of inpatient services cost? Enter </pre>				N	Ν	98. 03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII outpatient services cost? Enter "Y" for yes or " is column 2 for title XIX</pre>				N	Ν	98.04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" column 2 for title XIX.</pre>				Y	Y	98.05
98.06 Does title V or XIX follow Medicare (title XVIII Pts. I through IV? Enter "Y" for yes or "N" for column 2 for title XIX.				Y	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a CAH?				N		105.00
106.00 If this facility qualifies as a CAH, has it elect for outpatient services? (see instructions)	ted the all-i	nclusive met	hod of payment	N		106. 00
107.00 Column 1: If line 105 is Y, is this facility eli training programs? Enter "Y" for yes or "N" for Column 2: If column 1 is Y and line 70 or line approved medical education program in the CAH's	no in column 75 is Y, do y	1. (see ins ou train I&R	tructions) s in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (s 108.00 ls this a rural hospital qualifying for an excep CFR Section §412.113(c). Enter "Y" for yes or "N	ee instruction tion to the C	ons)		Ν		108.00
CFR Section 9412. 113(C). Enter Y for yes of N		Physi cal 1.00	Occupational 2.00		Respi ratory	_
109.00 If this hospital qualifies as a CAH or a cost pr therapy services provided by outside supplier? E for yes or "N" for no for each therapy.		1.00	2.00	3.00	4.00	109.00
, . ,				ı 	1.00	_
110.00 Did this hospital participate in the Rural Commu Demonstration) for the current cost reporting per	iod? Enter "Y	(" for yes or	"N" for no. I	f yes,	N	110.00
complete Worksheet E, Part A, lines 200 through applicable.	∠io, anu work	SHEEL E-2, I	1165 200 throu	ayn 210, 85		

Health Financial Systems PORTER MEMORIAL HOS	SPI TAL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN	l: 15-0035	Period: From 01/01/2019 To 12/31/2019		repared:
111.00 If this facility qualifies as a CAH, did it participate in the Fr Health Integration Project (FCHIP) demonstration for this cost re "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is particip Enter all that apply: "A" for Ambulance services; "B" for additio for tele-health services.	eporting pe 1 is Y, er Dating in c	eriod? Enter iter the column 2.	1.00 N	2.00	111.00
	-	1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Mo demonstration for any portion of the current cost reporting perio Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	od?	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" pe for short term hospital or "98" percent for long term care (inclu psychiatric, rehabilitation and long term hospitals providers) ba the definition in CMS Pub. 15-1, chapter 22, §2208.1.	E only) ercent ides ased on	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for y "N" for no.	es or	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? "Y" for yes or "N" for no.	'Enter	Ν			117.00
118.00 is the malpractice insurance a claims-made or occurrence policy? if the policy is claim-made. Enter 2 if the policy is occurrence.	Enter 1		1		118.00
118.01 List amounts of malpractice premiums and paid losses:		1.00 623,1	2. 00 27 1, 489, 77	3.00	0118.01
			1.00	2.00	_
<ul> <li>118.02 Are mal practice premiums and paid losses reported in a cost cente Administrative and General? If yes, submit supporting schedule I and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harm §3121 and applicable amendments? (see instructions) Enter in colu "N" for no. Is this a rural hospital with &lt; 100 beds that qualifi</li> </ul>	isting cos nless provi umn 1, "Y"	st centers sion in ACA for yes or		N	118. 02 119. 00 120. 00
Hold Harmless provision in ACA §3121 and applicable amendments? ( Enter in column 2, "Y" for yes or "N" for no.		-			101.00
121.00Did this facility incur and report costs for high cost implantabl patients? Enter "Y" for yes or "N" for no.		-	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is " the Worksheet A line number where these taxes are included.					122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes	and "N" f	or no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter t in column 1 and termination date, if applicable, in column 2.	he certifi	cation date			126.00
127.00 If this is a Medicare certified heart transplant center, enter th	ne certific	ation date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter th in column 1 and termination date, if applicable, in column 2.	ne certific	ation date			128.00
129.00  f this is a Medicare certified lung transplant center, enter the	e certifica	ntion date i	n		129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date if applicable, in column 2		fi cati on			130.00
date in column 1 and termination date, if applicable, in column 2 131.00 If this is a Medicare certified intestinal transplant center, ent	er the cer	ti fi cati on			131.00
date in column 1 and termination date, if applicable, in column 2 132.00 If this is a Medicare certified islet transplant center, enter th in column 1 and termination date, if applicable, in column 2		ation date			132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2. All Providers	) number ir	ı column 1			133. 00 134. 00
140.00 Are there any related organization or home office costs as define chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes,			Y	HB1848	140. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			HOSPITAL Provider CC	N: 15-00				Worksheet S- Part I Date/Time Pr 8/18/2020 12	epared:
1.00		2.00					3.00	0/10/2020 12	<u>. 24 piii</u>
If this facility is part of a cha					the n	ame and	d address	of the	
home office and enter the home of 141.00 Name: CHS/COMMUNITY HEALTH SYSTE INC			ONSIN PHYSICI		tracto	or's Nu	mber: 5228	0	141. 0
142.00 Street: 4000 MERIDIAN BLVD	PO Box:	SERV	ICES						142. 0
143. 00 Ci ty: FRANKLI N	State:	TN		Zi p	Code:		3706	7	143.0
								1.00	_
144.00 Are provider based physicians' cos	sts included in Works	sheet A?						Y	144. 0
				£			1.00 Y	2.00	145.0
<ul> <li>145.00 If costs for renal services are clippatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N"</li> <li>146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in</li> </ul>	for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p	no in co zation fo previousl	olumn 1. lf c or this cost y filed cost	olumn 1 reporti report	ng ?		N		145. 0 146. 0
yes, enter the approval date (mm/									
								1 00	_
147.00Was there a change in the statisti	cal basis? Enter "Y	" for ves	or "N" for	no.				1.00 N	147.0
148.00 Was there a change in the order o	°allocation? Enter '	"Y" for y	ves or "N" fo	r no.				N	148.0
149.00Was there a change to the simplifi	ed cost finding meth	hod? Ente						N	149.0
			Part A 1.00	Par 2.			itle V 3.00	Title XIX 4.00	-
Does this facility contain a prov	der that qualifies	for an ex				tion of			
or charges? Enter "Y" for yes or	'N" for no for each	componen <sup>-</sup>				(See 42			_
55.00Hospital 56.00Subprovider - IPF			N N	N			N N	N N	155. C
57. 00 Subprovider - IRF			N	N			N	N	157.0
58. 00 SUBPROVI DER									158. 0
59.00 SNF			N	N			N	N	159.0
160.00HOME HEALTH AGENCY 161.00CMHC			N	N			N N	N N	160. 0 161. 0
			1					1.00	_
Multicampus								1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that I	has one c	or more campu	ses in	di ffer	rent CB	ISAs?	N	165.0
	Name		County	State		Code	CBSA	FTE/Campus	_
166.00  fline 165 is yes, for each	0		1.00	2.00		8.00	4.00	5.00	00 166. 0
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									
								1.00	-
Health Information Technology (HI						t Act		-	
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1	05 is "Y") and is a m	meani ngfu	ıl user (line			enter	the	Y	167. C
68.01 If this provider is a CAH and is i	not a meaningful user	r, does t	his provider			a hard	lshi p		168. 0
exception under §413.70(a)(6)(ii)'									
69.00 If this provider is a meaningful transition factor. (see instruction		") and is	s not a CAH (	line 10	o IS'	N"), e	enter the	9.0	99169. C
							gi nni ng	Endi ng	
	antantan di Karata	and an I is	- 6 11				1.00	2.00	170.0
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	eginning date and er	naing dat	е тог the re	porting					170. C
							1 00	2 00	_
171.00 If line 167 is "Y", does this prov	vider have anv davs t	for indiv	i dual s enrol	led in			1.00 N	2.00	0171.0
section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (9	reported on Wkst. S-: umn 1. If column 1 is	3, Pt. I,	line 2, col	. 6? En		n			

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0035	Period:	Worksheet S-	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pr	
				Y/N	8/18/2020 12 Date	:24 pr
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			-
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	Y/N	Date	V/I	_
			1.00	2.00	3.00	-
00	Has the provider terminated participation in the Medicare Pr	rogram? [f	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in column					
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, including		Y			3.
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other relationships? (see instructions)	SIMITAL				
			Y/N	Туре	Date	
			1.00	2.00	3.00	+
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Certi	ified Public	N			4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					
	or "R" for Reviewed. Submit complete copy or enter date avai	ilable in				
~~	column 3. (see instructions) If no, see instructions.					-
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.
	those on the fired financial statements? If yes, submit reco	Sherriation.		Y/N	Legal Oper.	
				1,00	2.00	
	Approved Educational Activities				2100	
00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s Y	Y	6.
	the legal operator of the program?	-				
00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions.		Y		7.
00	Were nursing school and/or allied health programs approved a	and/or renewed	during the	N		8.
00	cost reporting period? If yes, see instructions.			N		
00	Are costs claimed for Interns and Residents in an approved g		cal education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		he current	N		10.
. 00	cost reporting period? If yes, see instructions.	Tenewed III I	the current	IN IN		10.
. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		
	Teaching Program on Worksheet A? If yes, see instructions.					11.
						11.
					Y/N	11.
				-	Y/N 1.00	11.
	Bad Debts				1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,				1.00 Y	12.
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			ost reporting	1.00	12.
8. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy.	olicy change o	luring this co		1.00 Y N	12. 13.
8. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymen	olicy change o	luring this co		1.00 Y	11. 12. 13. 14.
8. 00 4. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy.	olicy change o nts waived? If	during this co * yes, see ins	structions.	1.00 Y N	12. 13.
8. 00 4. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	olicy change on hts waived? If hg period? If	during this co * yes, see ins	structions.	1.00 Y N N Y	12. 13. 14.
8. 00 4. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	olicy change on hts waived? If hg period? If	luring this co yes, see ins yes, see ins t A Date	structions.	1.00 Y N N Y	12. 13. 14.
. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement Did total beds available change from the prior cost reportin	olicy change o nts waived? If ng period? If Par	during this co yes, see ins yes, see ins t A	structions.	1.00 Y N N Y t B	12. 13. 14.
. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement Did total beds available change from the prior cost reportin PS&R Data	olicy change of nts waived? If ng period? If Par Y/N 1.00	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions.	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
. 00 . 00 . 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po- period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payment Bed Complement Did total beds available change from the prior cost reportin PS&R Data Was the cost report prepared using the PS&R Report only?	olicy change o nts waived? 11 ng period? 1f Par Y/N	luring this co yes, see ins yes, see ins t A Date	structions.	1.00 Y N Y t B Date	12. 13. 14. 15.
. 00 . 00 . 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through	olicy change of nts waived? If par Par Y/N 1.00	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions.	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection properiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	olicy change of nts waived? If par Par Y/N 1.00	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions.	1.00 Y N Y t B Date 4.00	12. 13. 14.
. 00 . 00 . 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	olicy change of nts waived? If ng period? If Par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
. 00 . 00 . 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection properiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	olicy change of nts waived? If par Par Y/N 1.00	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions.	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
6. 00 6. 00 6. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-payment         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R Report for	olicy change of nts waived? If ng period? If Par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
6. 00 6. 00 6. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-payment         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	olicy change of nts waived? If ng period? If Par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
<ul> <li>a. 00</li> <li>b. 00</li> <li>c. 00</li> <li>c. 00</li> </ul>	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R	olicy change of nts waived? If ng period? If Par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00	1.00 Y N Y t B Date 4.00	12. 13. 14. 15. 16.
<ul> <li>a. 00</li> <li>b. 00</li> <li>c. 00</li> <li>c. 00</li> </ul>	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-payment         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	olicy change of nts waived? If par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00 Y	1.00 Y N Y t B Date 4.00	12. 13. 14. 15. 16.
8. 00 4. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-payment         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	olicy change of nts waived? If par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00 Y	1.00 Y N Y t B Date 4.00	12. 13. 14. 15.
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-paymer         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	olicy change o nts waived? If par Par Y/N 1.00 Y N N	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00 Y	1.00 Y N Y t B Date 4.00	12. 13. 14. 15. 16. 17. 18.
s. 00 s. 00 s. 00 s. 00	Bad Debts         Is the provider seeking reimbursement for bad debts? If yes,         If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.         If line 12 is yes, were patient deductibles and/or co-payment         Bed Complement         Did total beds available change from the prior cost reportion         PS&R Data         Was the cost report prepared using the PS&R Report only?         If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	blicy change of hts waived? If par Y/N 1.00 Y	Juring this co yes, see ins yes, see ins t A Date 2.00	ructions. Par Y/N 3.00 Y	1.00 Y N Y t B Date 4.00	12. 13. 14. 15. 16.

Heal th Financial	Systems
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PORTER MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provi der C	CN: 15-0035	Peri od: From 01/01/2019 To 12/31/2019		2 epared:
		Descri	ption	Y/N	Y/N	
		(	)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
					1.00	
-	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	Ν	26.00			
27.00	Has the provider's capitalization policy changed during th copy.	yes, submit	Ν	27.00		
~~ ~~	Interest Expense					
	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	. 0	N	28.00		
	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		N	29.00		
30.00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with new	debt? If yes,	see	N	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	see	Ν	31.00		
	Purchased Services					
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	uctions.	0		Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainin	g to competit	ive bidding? If	Y	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provi der-bas	ed physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the p	rovi der-based	Y	35.00
				Y/N	Date	
	1			1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	Ν	12/31/2018	38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			Ν		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfyes, see	Ν		40.00
	instructions.					
		2.	00			
	Cost Report Preparer Contact Information	h		DOMANUC		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VI CTORI A		ROMANKO		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	TH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333		VI CTORI A_ROMAN	KO@CHS. NET	43.00

Heal th	Financial Systems	PORTER MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der	CCN: 15-0035	Period: From 01/01/2019	Worksheet S-2 Part II	
					To 12/31/2019		pared: 24 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti-	tle/position 🖡	REVENUE MANA	GER			41.00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	t report					42.00
	preparer.						
43.00	Enter the telephone number and email addres	ss of the cost					43.00
	report preparer in columns 1 and 2, respec	ti vel y.					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Prep 8/18/2020 12:2	
						I/P Days / O/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	30. 00	192	70, 08	30 0.00	0	1.00 2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					Ő	6.00
7.00	Total Adults and Peds. (exclude observation		192	70, 08	0.00	0	7.00
8. 00 8. 01	beds) (see instructions) INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 31. 01	32 14	11, 68 5, 11		0	8. 00 8. 01
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		14	5, 11	0.00		9.00 10.00 11.00 12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		238	86, 87	0.00	0	14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF					0	15.00 16.00
17.00	SUBPROVIDER - IRF	41.00	14	5, 11	0	0	17.00
18.00	SUBPROVI DER	11.00		0, 11	0	Ű	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23.00 24.00
24.00	HOSPICE HOSPICE (non-distinct part)	30, 00					24.00
25.00	CMHC - CMHC	30.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALI FI ED HEALTH CENTER	89.00				0	26. 25
27.00	Total (sum of lines 14-26)		252				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00 32.00	Employee discount days - IRF Labor & delivery days (see instructions)		0		0		31.00 32.00
32.00	Total ancillary labor & delivery room		0		U I		32.00
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01

IOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 8/18/2020 12:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19, 806	1, 354	47, 11	7		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	10, 991	6, 278 0				2.00
1.00	HMO I RF Subprovider	298	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,40	0		0		5.00
5. 00 5. 00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	Ŭ	0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	19, 806	1, 354	47, 11	-		7.00
3.00	INTENSIVE CARE UNIT	2,865	53	5, 92	5		8.00
3. 01	NEONATAL INTENSIVE CARE UNIT	2,000	122				8.01
00.00	CORONARY CARE UNIT	-		_/ -/			9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		1, 563	2, 63			13.00
4.00	Total (see instructions)	22, 671	3, 092	58,50	0.00	1, 332. 44	•
5.00	CAH visits	0	0		0		15.00
6.00	SUBPROVIDER - IPF						16.00
7.00	SUBPROVIDER - IRF	2, 146	213	3, 15	0.00	15.07	
8.00	SUBPROVI DER						18.00
9.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
2.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)				0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1, 347. 51	27.00
28.00	Observation Bed Days		0	5, 04	2		28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	238	58	-		32.00
32.01	Total ancillary labor & delivery room				0		32.01
2 00	outpatient days (see instructions)	0					22 00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33. 00 33. 01

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PORTER MEMORIAL	Provider C	N· 15_0035	Peri od:	u of Form CMS-2 Worksheet S-3	
1103F1 1	AL AND HUSETTAL HEALTH CARE COMPLEX STATISTIC		FIOVIDELCO	JN. 15-0055	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	
						8/18/2020 12:	24 pm
		Full Time		Dis	charges		
		Equivalents	<b>T</b>			<b>T</b> 1 1 1 1	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	12.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00 4,3	14.00 07 1,631	15.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and		0	4, 5	1,031	11,000	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1,6	35 0		2.00
3.00	HMO I PF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation			1			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8. 01
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4, 3	07 1, 631	11, 868	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	1	96 19	294	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22.00 23.00
23.00	HOSPICE						23.00
24.00	HOSPICE (non-distinct part)						24.00
24.10	CMHC - CMHC						24.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days	0.00					28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00
22 01	LTCH site neutral days and discharges				0		33.01

SPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2019 o 12/31/2019		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	(col.2 ± col. 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
00	Total salaries (see	200.00	87, 585, 186	0	87, 585, 186	2, 960, 268. 00	29. 59	1. C
00	instructions) Non-physician anesthetist Part		C	0	0	0.00	0.00	2.0
	A							
00	Non-physician anesthetist Part B		C	0	0	0.00	0.00	3.0
00	Physician-Part A -		310, 126	0	310, 126	1, 534. 00	202. 17	4. (
01	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0.00	4.0
00	Physician and Non		C	0	0	0.00	0.00	5.0
00	Physician-Part B Non-physician-Part B for		C	0	0	0.00	0.00	6. (
	hospital-based RHC and FQHC							
00	services Interns & residents (in an	21.00	C	0	0	0.00	0.00	7.0
01	approved program)					0.00	0.00	
01	Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7.(
00	programs) Home office and/or related		C			0.00	0.00	8. (
	organi zati on personnel		C			0.00	0.00	
00 . 00	SNF Excluded area salaries (see	44.00	C 1, 121, 501	-	0 1, 121, 501	0. 00 36, 842. 00		
. 00	instructions)		1, 121, 501	0	1, 121, 301	30, 842. 00	30. 44	10.1
. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		3, 872, 564	0	3, 872, 564	44, 769. 00	86. 50	11.
. 00	Care		3, 072, 304		3, 072, 304	44, 769.00	00. 30	'''
. 00	Contract Labor: Top Level management and other		108, 077	0	108, 077	3, 244. 00	33. 32	12.
	management and administrative							
. 00	services Contract Labor: Physician-Part		403, 374	0	403, 374	2, 807. 00	143. 70	12
. 00	A - Administrative		403, 374		403, 374	2,007.00	143.70	15.
. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14.
	wage-related costs							
. 01 . 02	Home office salaries Related organization salaries		9, 423, 059 C		9, 423, 059			
. 02	Home office: Physician Part A		C		0	0.00		
00	- Administrative Home office and Contract		C	0	0	0.00	0.00	16
. 00	Physicians Part A - Teaching		C		0	0.00	0.00	10.
. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16.
. 02	Home office contract		C	0	0	0.00	0.00	16.
	Physicians Part A - Teaching WAGE-RELATED COSTS							
. 00	Wage-related costs (core) (see		22, 607, 282	. 0	22, 607, 282			17.
. 00	instructions) Wage-related costs (other)							18.
	(see instructions)							
. 00 . 00	Excluded areas Non-physician anesthetist Part		294, 313 C		294, 313 0			19. 20.
	A		C					
. 00	Non-physician anesthetist Part B		С	0	0			21.
. 00	Physician Part A -		24, 655	0	24, 655			22.
. 01	Administrative Physician Part A - Teaching		C	0	0			22.
. 00	Physician Part B		C	0	0			23.
. 00 . 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	-	0			24. 25.
	approved program)		-					
. 50	Home office wage-related (core)		1, 771, 893	0	1, 771, 893			25.
. 51	Related organization		C	0	0			25.
. 52	wage-related (core) Home office: Physician Part A		C	_	_			25.
52	- Administrative -		C C		I			20.

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII					-		
26.00	Employee Benefits Department	4.00			357, 12			26.00
27.00	Administrative & General	5.00	10, 856, 811	-201, 202				
28.00	Administrative & General under		495, 441	0	495, 44	1 33, 397. 24	14. 83	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0		0 0.00		
30.00	Operation of Plant	7.00	2,005,899		2, 005, 89			
31.00	Laundry & Linen Service	8.00	135, 853	0	135, 85		15. 19	31.00
32.00	Housekeepi ng	9.00	1, 544, 991	0	1, 544, 99	1 122, 256. 00	12.64	32.00
33.00	Housekeeping under contract		484, 056	0	484, 05	6 16, 089. 00	30.09	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 870, 901	-1, 099, 440	771, 46			34.00
35.00	Dietary under contract (see instructions)		324, 192	0	324, 19	2 6, 325.00	51.26	35.00
36.00	Cafeteria	11.00	0	1, 099, 440	1, 099, 44	0 73, 780. 00	14.90	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	3, 112, 249	201, 202	3, 313, 45	1 87, 961.00	37.67	38.00
39.00	Central Services and Supply	14.00	825, 483	0	825, 48	3 50, 093. 00	16. 48	39.00
40.00	Pharmacy	15.00	2, 867, 492	0	2, 867, 49	2 60, 540. 00	47.37	40.00
41.00	Medi cal Records & Medi cal	16.00	663, 024	0	663, 02	4 33, 562.00	19.76	41.00
	Records Library							
42.00	Soci al Servi ce	17.00	1, 398, 713	0	1, 398, 71	3 37, 626. 00	37.17	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00
				•				-

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period:	Worksheet S-3	
						From 01/01/2019 To 12/31/2019	Date/Time Pre	
							8/18/2020 12:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		88, 888, 875	0	88, 888, 87	5 3, 016, 079. 24	29.47	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 121, 501	0	1, 121, 50	1 36, 842. 00	30.44	2.00
	instructions)							
3.00	Subtotal salaries (line 1		87, 767, 374	0	87, 767, 37	4 2,979,237.24	29.46	3.00
	minus line 2)							
4.00	Subtotal other wages & related		13, 807, 074	0	13, 807, 07	4 365, 814. 00	37.74	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 403, 830	0	24, 403, 83	0.00	27.81	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		125, 978, 278	0	125, 978, 27	8 3, 345, 051. 24	37.66	6.00
7.00	Total overhead cost (see		26, 942, 225		26, 942, 22			7.00
	instructions)							
	· · ·					1	•	

Heal th	Financial Systems	PORTER MEMORIAL	HOSPI TAL			In L	ieu of Form CMS-	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN:	15-0035	Peri od:	Worksheet S-3	
						From 01/01/20		
						To 12/31/20	19 Date/Time Pre 8/18/2020 12:	
	· · · · · · · · · · · · · · · · · · ·						Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							
	Part A - Core List							1
	RETIREMENT COST							1
1.00	401K Employer Contributions						1, 795, 046	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrik	oution					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	structions)					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)						
5.00	401K/TSA Plan Administration fees						0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	an					0	6.00
7.00	Employee Managed Care Program Administration	n Fees					0	7.00
	HEALTH AND INSURANCE COST							
8.00	Health Insurance (Purchased or Self Funded)						0	8.00
8.01	Health Insurance (Self Funded without a Thir	<sup>-</sup> d Party Administr	ator)				0	8.01
8.02	Health Insurance (Self Funded with a Third F	Party Administrato	r)				13, 065, 869	8. 02
8.03	Health Insurance (Purchased)						0	8.03
9.00	Prescription Drug Plan						0	
10.00	Dental, Hearing and Vision Plan						231, 293	10.00
11.00	Life Insurance (If employee is owner or bene							11.00
12.00	Accident Insurance (If employee is owner or							12.00
13.00	Disability Insurance (If employee is owner of						210, 920	13.00
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary	)					14.00
15.00	'Workers' Compensation Insurance						1, 133, 295	15.00
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	ordinary a	accrua	al require	ed by FASB 106.	0	16.00
	Non cumulative portion)							
	TAXES							
	FICA-Employers Portion Only						5, 043, 909	
18.00	Medicare Taxes - Employers Portion Only						1, 179, 624	
19.00	Unemployment Insurance							19.00
20.00	State or Federal Unemployment Taxes						199, 711	20.00
	OTHER							
21.00	Executive Deferred Compensation (Other Than	Retirement Cost R	eported or	n line	es 1 throu	ugh 4 above. (se	e 0	21.00
~~ ~~	instructions))							
22.00	Day Care Cost and Allowances						0	
23.00	Tuition Reimbursement						0	
24.00	Total Wage Related cost (Sum of lines 1 -23)	l					22, 926, 250	24.00
05 00	Part B - Other than Core Related Cost							05.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems	PORTER MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN:	15-0035	Peri od:	Worksheet S-3	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	Cost Center Description				Contract Labor	Benefit Cost	24 pm
	obst center bescription				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					2100	
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost			3, 872, 564	22, 926, 250	1.00
2.00	Hospi tal				3, 872, 564	22, 926, 250	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
	Renal Dialysis				0	0	17.00
18.00	Other				0	0	18.00

Provider CCE: 15-003       Provider CCE: 15-003       Proof 01/07/07	Heal th	Financial Systems PORTER MEMORIAL H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
To         12/31/2019         Date/Time Prepared: Bit/2020 12.24 pm           1.00         Cost to charge ratio (Worksheet C, Part Line 202 column 3 divided by line 202 column 8)         1.00           2.00         Net revenue from Medicaid         35,218,680         2.00           2.00         Net revenue from Medicaid         35,218,680         2.00           3.00         If line 3 is systematral payments from Medicaid         2.00         3.00         4.00           0.01         If line 3 is systematral payments from Medicaid         2.00         4.00         2.8,445,900         6.00           0.01         If line 3 is systematral payments from Medicaid         2.00         5.00         6.00         8.00         2.01         5.00         6.00         8.00         2.01         5.00         6.00         8.00         2.01         5.00         6.00         8.00         2.01         5.00         6.00         8.00         2.01         5.00	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0035		Worksheet S-1	0
Uncompensated and indigent care cost computation         I.or           Log Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.1117378         1.00           Log Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.1117378         1.00           Log Data (See Instructions for each line)         35, 218, 680         2.00         35, 218, 680         2.00           Log Data (See Sine 2 in clude all DSH and/or supplemental payments from Medicaid 7         Y         3.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         4.00					To 12/31/2019		
Uncompensated and indigent care cost computation         I.or           Log Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.1117378         1.00           Log Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.1117378         1.00           Log Data (See Instructions for each line)         35, 218, 680         2.00         35, 218, 680         2.00           Log Data (See Sine 2 in clude all DSH and/or supplemental payments from Medicaid 7         Y         3.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         2.00         35, 218, 680         4.00						1.00	
1.00       Cost to charge ratio (Worksheet C, Pert I line 202 column 3) divided by line 202 column 8)       0.117378       1.00         2.00       Net revenue from Medicaid       35,218,680       2.00         3.00       Did you receive DSI or supplemental payments from Medicaid?       Y       3.02         4.00       If i line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid       Y       4.00         0.01       If line 4 is no, then entor DSH and/or supplemental payments from Medicaid       Y       4.00         0.01       Medicaid charges       2.04,845,900       6.00         0.01       Medicaid charges       0.01707       0.00         1.00       Stand-alone CHP cost (line 1 times line 10)       2.00       9.00       9.00         1.00       Stand-alone CHP cost (line 1 times line 10)       3.01 file file file file file file file file		Uncompensated and indigent care cost computation				1.00	
2.00       Net revenue from Medicaid       35,218,600       2,00       y         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y       4,00         4.00       IF line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       Y       4,00         5.00       IF line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       Y       4,00         6.00       Medicaid cost (line 1 times line 6)       2,814,533       7,00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       0       0         9.00       Stand-alone CHP Porages       2,9,00       9,00       2,9,10       2,9,10       3,495       12,00         10.00       Stand-alone CHP Porages       2,9,00       3,495       12,00       14,00       3,495       12,00         11.00       State or local indigent care program (Not included on lines 2, or 9)       0       13,00       14,00       14,00         12.00       Difference between net revenue and costs for state or local indigent care program (Not included on lines 2, or 9)       0       13,00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, or 9)       0       14,00         16.00       Difference between net revenue and costs	1.00		vided by lir	ne 202 column	ו 8)	0. 117378	1.00
3.00       Did you receive DSH or supplemental payments from Medicaid 7       Y       3.00         0.00       IF line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid       Y       4.00         5.00       IF line 4 is no, then enter DSH and/or supplemental payments from Medicaid       Y       4.00         6.00       Medicaid core (line 1 times line 6)       Bold caid core (line 1 times line 6)       Payments for Medicaid program (line 7 minus sum of lines 2 and 5; if       Y       9.00         0.01       Difference between ent revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       Y       9.00         0.01       Stand-alone CHP charges       29.77       9.00       0.01         0.10       Stand-alone CHP cost (line 1 times line 10)       3.485       11.00       3.485       11.00         1.00       Dtherence between ent revenue and costs for state or local indigent care program (Not included on lines 2, 5 or 9)       0       14.00         1.00       Dtherence between ent revenue and costs for state or local indigent care program (Not included in lines 6 or 10)       0       15.00       State or local indigent care program (State and local indigent care program (State 10 coal indigent care program (State 10 coa						1	
4.00       If fine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       Y       4.00         5.00       IF line 4 is no, then enter DSH and/or supplemental payments from Medicaid       5.00         6.00       Medicaid cost (line 1 times line 6)       228.445,900       6.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       28.814,533       7.00         7.00       Medicaid cost (line 1 times line 6)       0       8.00       9.00       8.00       9.00       8.00       9.00       8.00       9.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       0       5.00         6.00       Medicaid coards       5.00         7.00       Medicaid cost (line 1 times line 6)       20.814,533         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       2         9.00       Net revenue from stand-al one CHIP (see instructions for each line)       0         9.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			tal navmanta	from Modia	1 42		
6.00       Medicald charges       228, 445, 990       6.00         7.00       Medicald cost (line 1 times line 6)       26, 814, 503       7.00         8.00       DIfference between net revenue and costs for Medicald program (line 7 minus sum of lines 2 and 5; if       26, 814, 503       7.00         9.00       Net revenue from stand-alone CHIP (line 1 times line 10)       29, 779       10.00       51, 495       9.00         11.00       Stand-alone CHIP cost (line 1 times line 10)       29, 779       10.00       3, 495       11.00         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; If < zero then enter zero)							
7.00       Medicald cost <sup>2</sup> (line 1 times line 6)       26,814,533       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       26,814,533       7.00         9.00       Net revenue from stand-al one CHIP (see instructions for each line)       0       9.00       9.00         9.00       Stand-al one CHI P cost (line 1 times line 10)       3,495       11.00       3,495       12.00         0.01       Other state or local government indigent care program (See instructions for each line)       13.00       13.00       14.00       13.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       15.00						Ű	
< zero then enter zero)		5					
Children's Health Insurance Program (CHIP) (see instructions for each line)         0           9.00         Net revenue from stand-alone CHIP cost (line 1 times line 10)         0         0         29,779         10.00           10.00         Stand-alone CHIP cost (line 1 times line 10)         29,779         10.00         3,495         11.00           10.00         Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then atter or local indigent care program (Not included on lines 2, 5 or 9)	8.00		(line 7 minu	us sum of lir	nes 2 and 5; if	0	8.00
9. 00.       Net revenue from stand-al one CHP       0							
10.00       Stand-al one CHI P cost (line 1 times line 10)       29,779       10.00         11.00       Stand-al one CHI P cost (line 1 times line 10)       3,495       11.00         12.00       Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then 3,495	0.00		or each line	e)			0.00
11.00       Stand-alone CHIP cost (line 1 times line 10)       3.495       3.495       11.00         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
12.00       Difference between net revenue and costs for stand-allone CHIP (line 11 minus line 9; if < zero then							
enter zero)       Image: constructions for each line)         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)       15.00         17.00       For each line)       0       15.00         17.00       For each line)       0       16.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Private grants, appropriations for each line)       0       10.00       10.00       11.00         19.00       Cost or for Medicaid, CHIP and state and local indigent care programs (sum of lines 3, 495       19.00       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 00       3.00       18.00         19.00       Charity care (see instructions for each line)       10.01 sured       Insured       16.699.034       20.00         20.00       Charity care (see instructions)       10 charity care			(line 11 mir	nus line 9: i	f < zero then		
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00       Netarges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       14.00       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If < zero then enter zero)	12.00		(			6, 170	12:00
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line)       0       15.00         11.1       rf < zero then enter zero)						-	[
10)       100       1						-	
15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	14.00		e program (N	Not included	in lines 6 or	0	14.00
16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero). Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       17.00       Private grants, donations, or endowment income restricted to funding charity care 0       17.00       17.00         19.00       Dotal unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       0       0       0       0       0       18.00         19.00       Dotal unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       0       0       0       0       18.00       3.495       19.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       0       1.00       2.00       3.00       20.00	15 00		4)			0	15 00
13: if < zero then enter zero)				program (lin	ne 15 minus line	0	
instructions for each line)       17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       3,495       19.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       3,495       19.00         10.00       2.00       3.00       1.00       2.00       3.00         10.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16,637,670       61,364       16,699,034       20.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       1,952,896       61,364       2,014,260       21.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1,902,471       59,745       1,962,216       23.00         22.00       Payments received from patients for amounts previously written off as imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00       1,902,471       59,745       1,962,216       23.00         24.00       Does the amount on line 20 c	101.00		argont ouro	program (rri		, i i i i i i i i i i i i i i i i i i i	10100
17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       3,495       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       3,495       19.00         10.00       2.00       3.00       Total (coil 1       + coil 2)       1         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16,637,670       61,364       16,699,034       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1,952,896       61,364       2,014,260       21.00         22.00       Payments received from patients for amounts previously written off as 50,425       1,619       52,044       22.00         23.00       Cost of charity care (line 21 minus line 22)       1,902,471       59,745       1,962,216       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00			IP and state	e∕local indig	gent care program	ns (see	
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines)       3,495       19.00         0       Uninsured patients       Insured patients       Total (col. 1       1         0       Charity care charges and uninsured discounts for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16,637,670       61,364       16,699,034       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1,952,896       61,364       2,014,260       21.00         22.00       Payments received from patients for amounts previously written off as charity care       50,425       1,619       52,044       22.00         23.00       Cost of charity care (line 21 minus line 22)       1,902,471       59,745       1,962,216       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       14,904,664       26.00         26.00       Total ba	17 00		undi na chori	ty care		0	17 00
19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 495 19.00 8, 12 and 16)       3, 495 19.00         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 1, 20 1)       Total (col. 1)         Image: Instruction of the state and local indigent care programs (sum of lines 2, 20 0)       Total (col. 1)         Image: Instruction of the state and uninsured discounts (see instructions)       Image:							
Uncompensated Care (see instructions for each line)Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)16,637,67061,36416,699,03420.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1,952,89661,3642,014,26021.0022.00Payments received from patients for amounts previously written off as charity care50,4251,61952,04422.0023.00Cost of charity care (line 21 minus line 22)1,902,47159,7451,962,21623.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 		Total unreimbursed cost for Medicaid, CHIP and state and local			s (sum of lines		
Incompensated Care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility16, 637, 67061, 36416, 699, 03420.0021.00Cost of patients approved for charity care and uninsured discounts (see1, 952, 89661, 3642, 014, 26021.0021.00Cost of patients approved for charity care and uninsured discounts (see1, 952, 89661, 3642, 014, 26021.0022.00Payments received from patients for amounts previously written off as50, 4251, 61952, 04422.0023.00Cost of charity care1, 902, 47159, 7451, 962, 21623.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0024.00Does the amount on line 20 column 2, include charges for patient days beyond the indigent care program?1.0025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14, 904, 66426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)758, 78727.0128.00Non-Medicare allowable bad debts for the entire hospital complex (see instructions)14, 145, 87728.0029.00Cost of nucompensated care (line 23 column 3 plus line 29)3, 888, 20730, 887, 73030, 703				Uni nsured	Insured	Total (col. 1	
Uncompensated Care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)16,637,670 eta,647,67061,364 eta,647,67016,699,034 eta,647,67020.00 eta,647,67021.00Cost of patients approved for charity care and uninsured discounts (see instructions)1,952,89661,364 eta,647,6702,014,26021.00 eta,64422.00Payments received from patients for amounts previously written off as charity care50,4251,61952,044 eta,64722.00 eta,64723.00Cost of charity care (line 21 minus line 22)1,902,47159,7451,962,216 eta,64723.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit24.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,664 493,211 27.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)14,404,664 493,211 27.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)758,787 27.01 14,145,877 28.0029.00Cost of non-Medicare bad debt expense (see instructions)14,45,877 29.0229.00Cost of non-Medicare du non-reimbursable Medicare bad debt expense (see instructions)14,925,991 29.00 3,888,20729.00Cost of unc			_				
20. 00Charity care charges and uninsured discounts for the entire facility (see instructions)16, 637, 67061, 36416, 699, 03420. 0021. 00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 952, 89661, 3642, 014, 26021. 0022. 00Payments received from patients for amounts previously written off as charity care50, 4251, 61952, 04422. 0023. 00Cost of charity care (line 21 minus line 22)1, 902, 47159, 7451, 962, 21623. 0024. 00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24. 0025. 00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025. 0026. 00Total bad debt expense for the entire hospital complex (see instructions)14, 904, 66426. 0027. 01Medicare reimbursable bad debts for the entire hospital complex (see instructions)14, 904, 66426. 0027. 01Medicare allowable bad debts for the entire hospital complex (see instructions)14, 904, 66426. 0028. 00Non-Medicare allowable bad debts for the entire hospital complex (see instructions)14, 403, 87727. 0129. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14, 925, 99129. 0030. 00Cost of nucompensated care (line 23 column 3 plus line 29)3, 888, 20730. 00		Uncomponented Corp (and instructions for each line)		1.00	2.00	3.00	
(see instructions)1,952,89661,3642,014,26021.0022.00Payments received from patients for amounts previously written off as charity care50,4251,61952,04422.0023.00Cost of charity care (line 21 minus line 22)1,902,47159,7451,962,21623.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)14,904,66426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)758,78727.0128.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14,145,7728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00	20 00		cility I	16, 637, 6	70 61 364	16,699,034	20 00
21. 00Cost of patients approved for charity care and uninsured discounts (see instructions)1, 952, 89661, 3642, 014, 26021. 0022. 00Payments received from patients for amounts previously written off as charity care50, 4251, 61952, 04422. 0023. 00Cost of charity care (line 21 minus line 22)1, 902, 47159, 7451, 962, 21623. 0024. 00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24. 0025. 00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025. 0026. 00Total bad debt expense for the entire hospital complex (see instructions)14, 904, 66426. 0027. 01Medicare reinbursable bad debts for the entire hospital complex (see instructions)78, 78727. 0028. 00Non-Medicare bad debt sfor the entire hospital complex (see instructions)14, 145, 87728. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14, 145, 87728. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)3, 888, 20730. 00	20.00					,,	
22.00Payments received from patients for amounts previously written off as charity care50,4251,61952,04422.0023.00Cost of charity care (line 21 minus line 22)1,902,47159,7451,962,21623.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare relimbursable bad debts for the entire hospital complex (see instructions)144,904,66426.0027.01Medicare bad debt expense (see instructions)758,78777.0128.00Non-Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00	21.00	Cost of patients approved for charity care and uninsured discou	unts (see	1, 952, 89	61, 364	2, 014, 260	21.00
23.00       Cost of charity care (line 21 minus line 22)       1,902,471       59,745       1,962,216       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program? s length of stay limit       N       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       14,904,664       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       493,211       27.00         28.00       Non-Medicare bad debt expense (see instructions)       14,145,877       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       14,145,877       28.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       3,888,207       30.00	22.00	Payments received from patients for amounts previously written	off as	50, 42	25 1, 619	52, 044	22.00
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)14,904,66427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)78,78727.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00	23.00			1, 902, 4	71 59, 745	1, 962, 216	23.00
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)14,904,66427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)78,78727.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00						1 00	
imposed on patients covered by Medicaid or other indigent care program?025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)14,904,66426.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)493,21127.0028.00Non-Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)14,25,97129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00	24.00	Does the amount on line 20 column 2, include charges for patien	nt davs bevo	ond a length	of stav limit		24.00
26.00Total bad debt expense for the entire hospital complex (see instructions)14,904,66426.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)493,21127.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)758,78727.0128.00Non-Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00		imposed on patients covered by Medicaid or other indigent care	program?	0	3	0	25.00
27.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)493,21127.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)758,78727.0128.00Non-Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00			-		-		
27.01 28.00 29.00Medicare allowable bad debts for the entire hospital complex (see instructions)758,787 14,145,877 28.00 14,145,877 29.00 30.00758,787 14,145,877 29.00 3,888,20727.01 14,145,877 29.00 3,888,207							
28.00Non-Medicare bad debt expense (see instructions)14,145,87728.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00							
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,925,99129.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)3,888,20730.00			see instruct	nons)			
30.00         Cost of uncompensated care (line 23 column 3 plus line 29)         3,888,207         30.00			nense (see i	nstructions			
			pense (see 1		,		
			ine 30)				

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	PORTER MEMORIA F EXPENSES	Provider CO	CN: 15-0035	Peri od:	Worksheet A	2552
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	-
	GENERAL SERVICE COST CENTERS						
00	00100 CAP REL COSTS-BLDG & FIXT		4, 465, 372	4, 465, 37	2 2, 586, 324	7, 051, 696	1.
00	00200 CAP REL COSTS-MVBLE EQUIP		9, 876, 359			10, 854, 600	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	357, 120	353, 960				
00	00500 ADMINI STRATI VE & GENERAL	10, 856, 811	65, 635, 949				
00	00700 OPERATION OF PLANT	2,005,899	7,005,654	9, 011, 55		12, 588, 380	
00	00800 LAUNDRY & LINEN SERVICE	135, 853	1, 288, 829			1, 417, 697	
00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 544, 991	1, 760, 031	3, 305, 02			
00 00	01100 CAFETERIA	1, 870, 901 0	1, 151, 261 0	3, 022, 16	2 -1, 814, 660 0 1, 720, 861	1, 207, 502	
00	01300 NURSI NG ADMI NI STRATI ON	3, 112, 249	436, 743			1, 720, 861 3, 746, 341	
00	01400 CENTRAL SERVICES & SUPPLY	825, 483	22, 585, 584	23, 411, 06		1, 297, 247	
00	01500 PHARMACY	2, 867, 492	29, 445, 371	32, 312, 86			
00	01600 MEDI CAL RECORDS & LI BRARY	663, 024	1, 208, 294			1, 871, 318	
00	01700 SOCIAL SERVICE	1, 398, 713	221, 414				
00	INPATIENT ROUTINE SERVICE COST CENTERS	1,070,710	221, 111	1, 020, 12	, 0	1, 020, 127	1
00	03000 ADULTS & PEDIATRICS	16, 171, 006	4, 473, 712	20, 644, 71	8 -872, 711	19, 772, 007	30
00	03100 INTENSIVE CARE UNIT	4, 697, 353	3, 387, 055	8, 084, 40	8 -80, 457	8, 003, 951	31
01	03101 NEONATAL INTENSIVE CARE UNIT	1, 514, 881	978, 949	2, 493, 83	0 6, 725	2, 500, 555	31
00	04100 SUBPROVIDER - IRF	1, 055, 447	264, 990	1, 320, 43	7 -4, 411	1, 316, 026	41
00	04300 NURSERY	1, 863	58, 186	60, 04	9 658, 922	718, 971	43
~ ~	ANCI LLARY SERVICE COST CENTERS	5 000 007	0.0/0.007			47 447 450	1
00	05000 OPERATING ROOM	5, 882, 287	8, 960, 887	14, 843, 17			
00	05100 RECOVERY ROOM	2, 257, 012	365, 419			0	
00	05200 DELIVERY ROOM & LABOR ROOM	1, 738, 703	764, 428			2, 654, 522	
00	05300 ANESTHESI OLOGY	0	2, 210, 332			2, 210, 246	
00	05400 RADI OLOGY-DI AGNOSTI C	5, 785, 449	2, 202, 482	7, 987, 93			
01	05401 ULTRASOUND	432, 950	86, 046			0	
00 00	05600 RADI OI SOTOPE	355, 517	634, 730			0	
00	05700 CT SCAN 05800 MRI	583, 988 225, 346	236, 988 200, 929			0	
00	06000 LABORATORY	4, 789, 746	6, 464, 994				
00	06500 RESPIRATORY THERAPY	1, 860, 545	605, 355			2, 339, 925	
00	06600 PHYSI CAL THERAPY	1, 944, 020	336, 087	2, 403, 90		2, 339, 923	
00	06700 OCCUPATI ONAL THERAPY	739, 313	54, 392	793, 70		793, 705	
00	06800 SPEECH PATHOLOGY	590, 812	44, 835			635, 647	
00	06900 ELECTROCARDI OLOGY	3, 765, 678	6, 351, 569			9, 816, 282	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,700,070	0,001,007		0 2, 620, 168		
00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 717, 623		
00	07300 DRUGS CHARGED TO PATIENTS	124, 101	24, 142				
00	07400 RENAL DI ALYSI S	0	719, 949			719, 949	
	03950 ANCI LLARY	0	0		0 0	0	
	03610 SLEEP LAB	289, 963	45, 181	335, 14	4 -335, 144		
03	03951 WOUND CARE	847, 182	740, 379			1, 587, 561	76
	OUTPATIENT SERVICE COST CENTERS						
00	09000 CLI NI C	0	0		0 0	0	
00	09100 EMERGENCY	6, 227, 434	6, 019, 114	12, 246, 54	8 -10, 149	12, 236, 399	91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS	07 510 100	101 // 5 051	270 105 00	2 04	270 105 1/7	1110
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)           NONREIMBURSABLE COST CENTERS	87, 519, 132	191, 665, 951	279, 185, 08	3 84	279, 185, 167	1118
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	66, 054	10, 882	76, 93	6 0	76, 936	1100
	19200 PHYSICIANS' PRIVATE OFFICES	00,034	431	43			192
	19201 OTHER NONREI MBURSABLE	0	431		0 0		192
	07950 NONREI MBURSABLE	0	0		0 0		192
	07950 NORRET MOURSABLE	0	0		0 0		194
	07951 MARKETING 07952 SENIOR CIRCLE	0	0		0 0		194
	07952 SENTOR CIRCLE	0	0		0 0		194
	07954 VACANT UNFINISHED AREA	0	0		0 0		194
1. O4							

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	PORTER MEMORIA F EXPENSES	AL HOSPITAL Provider CC	N: 15-0035	In Lie Period:	u of Form CMS Worksheet A	-2552-10
					From 01/01/2019 To 12/31/2019	Date/Time Pr 8/18/2020 12	epared:
	Cost Center Description		Net Expenses For Allocation			0/ 10/ 2020 12	
	GENERAL SERVICE COST CENTERS	6.00	7.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT	1,025,305	8,077,001				1.00
2.00	00200 CAP REL COSTS MVBLE EQUIP	-1, 135, 491	9, 719, 109				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 072	17, 331, 618				4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	3, 274, 307	60, 030, 098				5.00
7.00	00700 OPERATION OF PLANT	-188, 785					7.00
	00800 LAUNDRY & LINEN SERVICE		12, 399, 595				
8.00 9.00	00900 HOUSEKEEPING	0	1, 417, 697				8.00 9.00
9.00 10.00	01000 DI ETARY	0	3, 303, 844				10.00
11.00	01100 CAFETERIA	0	1, 207, 502 1, 720, 861				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-8, 021	3, 738, 320				13.00
14.00			1				14.00
	01400 CENTRAL SERVICES & SUPPLY	0	1, 297, 247				
15.00		-	3, 252, 377				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1, 393	1, 869, 925				16.00
17.00	01700 SOCIAL SERVICE	0	1, 620, 127				17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-1, 126, 212	18, 645, 795				30.00
30.00	03100 I NTENSI VE CARE UNI T	-2, 277, 408	5, 726, 543				31.00
31.00	03101 NEONATAL INTENSIVE CARE UNIT	-760, 400	1, 740, 155				31.00
41.00	04100 SUBPROVIDER - IRF	-700,400	1, 316, 026				41.00
43.00	04300 NURSERY	0	718, 971				43.00
10.00	ANCI LLARY SERVI CE COST CENTERS		/10, //1				
50.00	05000 OPERATING ROOM	-3, 058, 608	14, 059, 044				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-202, 750	2, 451, 772				52.00
53.00	05300 ANESTHESI OLOGY	-2, 114, 992	95, 254				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-397, 387	9, 181, 364				54.00
54.01	05401 ULTRASOUND	0	0				54.01
56.00	05600 RADI OI SOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MRI	0	0				58.00
60.00	06000 LABORATORY	0	10, 934, 754				60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 339, 925				65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 280, 107				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	793, 705				67.00
68.00	06800 SPEECH PATHOLOGY	0	635, 647				68.00
69.00	06900 ELECTROCARDI OLOGY	-3, 716, 052	6, 100, 230				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 620, 168				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	18, 717, 623				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28, 605, 895				73.00
74.00	07400 RENAL DIALYSIS	0	719, 949				74.00
76.00	03950 ANCI LLARY	0	0				76.00
76.01	03610 SLEEP LAB	0	0				76.01
76.03	03951 WOUND CARE	-19, 800	1, 567, 761				76.03
	OUTPATIENT SERVICE COST CENTERS	i i i i i i i i i i i i i i i i i i i	1				
	09000 CLINIC	0	0				90.00
91.00	09100 EMERGENCY	-3, 577, 900	8, 658, 499				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
110 00	SPECIAL PURPOSE COST CENTERS	14 200 (50	264 004 500				110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-14, 290, 659	264, 894, 508				118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76, 936				190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	347				190.00
	19201 OTHER NONREIMBURSABLE		0				192.00
	07950 NONREI MBURSABLE		0				192.01
	07950 NONRET MBORSABLE		0				194.00
	207952 SENIOR CIRCLE	0	0				194.01
	07952 SENTOR CIRCLE	0	0				194.02
	07954 VACANT UNFINISHED AREA	0	0				194.03
200.00		-14, 290, 659	264, 971, 791				200.00

ASSI F	FI CATI ONS			Provider CCN: 15-	0035 Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Prepare
					10 12/31/2019	8/18/2020 12: 24 p
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	- EMPLOYEE BENEFITS		-			
EN	<u>MPLOYEE BENEFITS DEPARTMENT</u>	4.00	0	<u>16, 625, 8</u> 25 16, 625, 825		1.
C	- RENTAL AND LEASE EXPENSES		<u> </u>	10, 025, 625		
	AP REL COSTS-BLDG & FIXT	1.00	0	301, 905		1.
CA	AP REL COSTS-MVBLE EQUIP	2.00	О	860, 518		2
	MERGENCY	91.00	0	5, 694		3
	ADI OLOGY-DI AGNOSTI C	54.00	0	10, 018		4
MF	RI	58.00 0.00	0	850 0		5
		0.00	0	0		7
		0.00	o	0		8
		0.00	О	0		9
0		0.00	0	0		10
0		0.00	0	0		11
0		0. 00 0. 00	0	0		12
0		0.00	0	0		13
Ŭ	+		0	1, 178, 985		14
D	- OTHER CAPITAL COSTS	I	<u> </u>	.,		
CA	AP REL COSTS-BLDG & FIXT	1.00	0	292, 869		1
	AP REL COSTS-BLDG & FIXT	1.00	0	1, 991, 550		2
CA	AP REL COSTS-MVBLE EQUIP	2.00	0	<u>117, 723</u> 2, 402, 142		3
F	- REPAIRS AND MAINTENANCE CO	STS	U	2,402,142		
	PERATION OF PLANT	7.00	0	3, 579, 452		1
NE	EONATAL INTENSIVE CARE UNIT	31.01	О	6, 725		2
	ELIVERY ROOM & LABOR ROOM	52.00	0	11		3
		0.00	0	0		4
		0.00 0.00	0	0		5
		0.00	0	0		7
		0.00	0	Ö		8
		0.00	О	0		9
0		0.00	0	0		10
0		0.00	0	0		11
0		0. 00 0. 00	0	0		12
0		0.00	0	0		14
0		0.00	0	Ö		15
0		0.00	О	0		16
0		0.00	0	0		17
0		0.00	0	0		18
0		0. 00 0. 00	0	0		19 20
0		0.00	0	0		20
0		0.00	õ	Ő		22
0		0.00	0	0		23
0		0.00	•	0		24
0	- CHIEF NURSING OFFICER COST		0	3, 586, 188		
	JRSI NG ADMI NI STRATI ON	13.00	201, 202	0		1
0			201, 202	<u>0</u>		
	- MEDI CAL SUPPLI ES					
	EDI CAL SUPPLI ES CHARGED TO	71.00	0	2, 620, 168		1
- P. S.	ATTENT MPL. DEV. CHARGED TO	72.00	0	18, 717, 623		2
	ATLENTS	/2.00	U	10, 717, 023		
	PERATING ROOM	50.00	0	<u>618, 9</u> 80		3
0			0	21, 956, 771		
	- COST OF DRUGS/IV SOLUTIONS			00.470.445		
DR	RUGS_CHARGED_TO_PATIENTS	<u>73.</u> 00	0	<u>28, 472, 612</u> 28, 472, 612		1
U	- LABOR AND DELIVERY COSTS		U	28, 472, 612		
	OULTS & PEDIATRICS	30.00	0	94, 585		1
NL	JRSERY	43.00	561, 950	96, 972		2
DE	ELIVERY ROOM & LABOR ROOM	52.00	34 <u>2, 9</u> 37	0		3
0			904, 887	191, 557		
	- RECOVERY ROOM PERATING ROOM	EO OO	2, 257, 012	365, 419		1.
101-		50.00	2, 257, 012			I _ I

Health Financial Systems			PORTER MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provider C	CN: 15-0035	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 8/18/2020 12	epared: 24 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	L - OTHER RADIOLOGY COST							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 597, 801	765, 651				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
	0		1, 597, 801	765, 651				
	M - DIETARY COSTS TO CAFETERI	A						
1.00	CAFETERI A	11.00	1, 099, 440	621, 421				1.00
	0		1, 099, 440	621, 421				
	0 - SLEEP LAB COSTS TO EKG							
1.00	ELECTROCARDI OLOGY	69.00	289, 963	42, 717				1.00
	0		289, 963	42, 717				
500.00	Grand Total: Increases		6, 350, 305	76, 209, 288				500.00

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RECLASSI FI CATI ON	S

In Lieu of Form CMS-2552-10

Provider CCN: 15-0035

Period: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					'	0 12/31/2019 Date/11me F 8/18/2020 1	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - EMPLOYEE BENEFITS	7.00	8.00	9.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 625, 825	0		1.00
			0	16, 625, 825			1.00
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	412, 179			1.00
2.00	OPERATION OF PLANT DIETARY	7.00 10.00	0	2, 625			2.00
3.00 4.00	SLEEP LAB	76.01	0	15, 885 2, 464			3.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	7, 796	-		5.00
6.00	PHARMACY	15.00	0	407, 811			6.00
7.00	ADULTS & PEDIATRICS	30.00	0	60, 944			7.00
8.00	INTENSIVE CARE UNIT	31.00	0	48, 344			8.00
9.00 10.00	SUBPROVIDER – IRF OPERATING ROOM	41.00 50.00	0	4, 308			9.00 10.00
10.00	LABORATORY	60.00	0	40, 127 54, 052			11.00
12.00	RESPI RATORY THERAPY	65.00	0	98, 111	0		12.00
13.00	ELECTROCARDI OLOGY	69.00	0	18, 731	0		13.00
14.00	LAUNDRY & LINEN SERVICE	8.00	0	5,608			14.00
	0		0	1, 178, 985			
1 00	D - OTHER CAPITAL COSTS ADMINISTRATIVE & GENERAL	E 00	0	2 402 142	10		1 00
1.00 2.00	ADMINISTRATIVE & GENERAL	5.00 0.00	0	2, 402, 142 0			1.00 2.00
3.00		0.00	0	0	13		3.00
0.00	0		— — — <del>•</del>	2,402,142			0.00
	E - REPAIRS AND MAINTENANCE (	COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	215			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	95, 621			2.00
3.00	HOUSEKEEPING	9.00	0	1, 178			3.00
4.00 5.00	DI ETARY CENTRAL SERVICES & SUPPLY	10. 00 14. 00	0	77, 914 149, 253			4.00 5.00
6.00	PHARMACY	15.00	0	180, 063			6.00
7.00	ADULTS & PEDIATRICS	30.00	0	1, 465			7.00
8.00	INTENSIVE CARE UNIT	31.00	0	32, 113	0		8.00
9.00	OPERATING ROOM	50.00	0	926, 806			9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	782, 650			10.00
11. 00 12. 00	ULTRASOUND RADI OI SOTOPE	54. 01 56. 00	0	25, 622 53, 974			11.00 12.00
12.00	CT SCAN	57.00	0	136, 598			13.00
14.00	MRI	58.00	0	177, 698			14.00
15.00	LABORATORY	60.00	0	265, 934	0		15.00
16.00	RESPI RATORY THERAPY	65.00	0	27, 864			16.00
17.00	ELECTROCARDI OLOGY	69.00	0	614, 914			17.00
18. 00 19. 00	EMERGENCY LAUNDRY & LINEN SERVICE	91.00 8.00	0	15, 843 1, 377			18.00 19.00
20.00	NURSING ADMINISTRATION	13.00	0	3, 853			20.00
21.00	SUBPROVI DER – I RF	41.00	0	103			21.00
22.00	ANESTHESI OLOGY	53.00	0	86			22.00
23.00	DRUGS CHARGED TO PATIENTS	73.00	0	14, 960			23.00
24.00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	84			24.00
		<u> </u>	0	3, 586, 188			_
1.00	F - CHIEF NURSING OFFICER COS ADMINISTRATIVE & GENERAL	5.00	201, 202	0	0		1.00
1.00			201, 202	0			1.00
	G - MEDICAL SUPPLIES	·					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	21, 956, 771	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	<u>0</u>		3.00
	U H - COST OF DRUGS/IV SOLUTION	21	U	21, 956, 771			-
1.00	PHARMACY	15.00	0	28, 472, 612	0		1.00
	0		o	28, 472, 612			1
	I - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	904, 887	0			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	191, 557	0		2.00
3.00			0		<u> </u>		3.00
	U K - RECOVERY ROOM	<u> </u>	904, 887	191, 557	<u> </u>		-
1.00	RECOVERY ROOM	51.00	2, 257, 012	365, 419	0		1.00
	0		2, 257, 012	365, 419			
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54.01	432, 950	60, 424			1.00
2.00	RADI OI SOTOPE	56.00	355, 517	580, 756			2.00
3.00 4.00	CT SCAN MRI	57.00 58.00	583, 988 225, 346	100, 390 24, 081			3.00
4.00		58.00	225, 346	24, U8 I	U		4.00

Heal th	Financial Systems		PORTER MEMORIA	L HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASSI FI CATI ONS				Provider (	CCN: 15-0035	Period: From 01/01/2019	Worksheet A-	6
						To 12/31/2019	Date/Time Pr 8/18/2020 12	epared: :24_pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	0		1, 597, 801	765, 651				
	M - DIETARY COSTS TO CAFETERI	A						
1.00	DI ETARY	10.00	1, 099, 440	621, 421		0		1.00
	0		1, 099, 440	621, 421				
	0 - SLEEP LAB COSTS TO EKG							
1.00	SLEEP LAB	76.01	289, 963	42, 717		0		1.00
	0		289, 963	42, 717		7		
500.00	Grand Total: Decreases		6, 350, 305	76, 209, 288				500.00

Heal th	Financial Systems	PORTER MEMORI	AL HOSPITAL			Inlie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Fro To	i od: m 01/01/2019 12/31/2019	Worksheet A-7 Part I	pared:
				Acqui si ti on	s			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	2, 949, 373	0		0	0	0	1.00
2.00	Land Improvements	3, 506, 326	0		0	0	0	2.00
3.00	Buildings and Fixtures	166, 692, 824	0		0	0	0	3.00
4.00	Building Improvements	7, 282, 183			0	444, 495		4.00
5.00	Fixed Equipment	6, 823, 022	103, 274		0	103, 274		5.00
6.00	Movable Equipment	68, 335, 352	5, 936, 291		0	5, 936, 291	1, 165, 287	6.00
7.00	HIT designated Assets	17, 693, 766	0		0	0	201, 812	7.00
8.00	Subtotal (sum of lines 1-7)	273, 282, 846	6, 484, 060		0	6, 484, 060	1, 436, 157	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	273, 282, 846	6, 484, 060		0	6, 484, 060	1, 436, 157	10.00
		Endi ng Bal ance	Fully					
			Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	2, 949, 373						1.00
2.00	Land Improvements	3, 506, 326	0					2.00
3.00	Buildings and Fixtures	166, 692, 824	0					3.00
4.00	Building Improvements	7, 691, 790	0					4.00
5.00	Fixed Equipment	6, 892, 126	0					5.00
6.00	Movable Equipment	73, 106, 356	0					6.00
7.00	HIT designated Assets	17, 491, 954	0					7.00
8.00	Subtotal (sum of lines 1-7)	278, 330, 749	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	278, 330, 749	0					10.00

Heal th	Financial Systems	PORTER MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0035	Period: From 01/01/2019	Worksheet A-7 Part II	
					To 12/31/2019		
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 465, 372	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 876, 359	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	14, 341, 731	0		0 0	0	3.00
		SUMMARY O					
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 465, 372				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9, 876, 359				2.00
3.00	Total (sum of lines 1-2)	0	14, 341, 731				3.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 8/18/2020 12:2	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	180, 840, 313				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	97, 490, 435				0	2.00
3.00 Total (sum of lines 1-2)	278, 330, 748		=: 0   0 0 0   : :		0	3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1		-		
1.00 CAP REL COSTS-BLDG & FIXT	0			0 4, 761, 579		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 8, 740, 868		2.00
3.00 Total (sum of lines 1-2)	0	0		0 13, 502, 447	1, 162, 423	3.00
		. Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	11.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	729,098	292, 869	1, 991, 55	0 0	8, 077, 001	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 0	9, 719, 109	2.00
3.00 Total (sum of lines 1-2)	729, 098			0 0	17, 796, 110	3.00

h	Fi nanci al	Systems	

	Financial Systems MENTS TO EXPENSES		PORTER MEMORIA	AL HOSPITAL Provider CCN: 15-0035	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
1.50001					From 01/01/2019 To 12/31/2019		
				Expense Classification To/From Which the Amount i			
				TO/TTOM WITCH THE AMOUNT I	s to be Aujusted		
			0	Cont Conton	1:		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		00	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay	А	-76, 018	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service	А	-188, 785	OPERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician	A-8-2	-17, 253, 345			0	10.00
11.00	adjustment Sale of scrap, waste, etc.	В	OI	RADI OLOGY-DI AGNOSTI C	54.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	9, 899, 330			0	12.00
	transactions (chapter 10)	A-0-1					
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00		13.00 14.00
15.00	Rental of quarters to employee		0		0.00		15.00
16.00	and others Sale of medical and surgical		О		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than		О		0.00	0	17.00
18.00	patients Sale of medical records and	В	-1, 393	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health		o		0.00	0	19.00
19.00	education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		о		0.00	0	20. 00
	Income from imposition of		0		0.00		21.00
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	OI	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
21.00	therapy costs in excess of						21.00
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted **	* 114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL	А	86, 041	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-1, 838, 340	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted **			28.00
	Physicians' assistant		0	cost center bereted	0.00		28.00 29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	00	OCCUPATIONAL THERAPY	67.00		30.00
20.00	limitation (chapter 14)						20.00
30. 99	Hospice (non-distinct) (see instructions)		0/	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
00.00	limitation (chapter 14)		_			_	22.02
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	В	-8, 021	NURSING ADMINISTRATION	13.00	0	33.00

Heal th	Financial Systems		PORTER MEMORI	AL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019		
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC. NON PATIENT REVENUE	В	-250, 664	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	NON-ALLOWABLE LEGAL FEES	A	-25, 773	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES WAGE COSTS	A	-19, 378	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT PHONES BENEFITS COSTS	A	-5,072	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.04
33.05	PATIENT TV DEPRECIATION	A	-4, 431	CAP REL COSTS-MVBLE EQUIP	2.00		33.05
33.06	MARKETING	A	-752, 011	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-667, 521	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN	A	-12, 093	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
	ASSOCIATION DUES						
33.09	CHARI TABLE CONTRI BUTI ONS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10	MEMBERSHIP DUES	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.10
33. 11	MINORITY INTEREST	A		ADMI NI STRATI VE & GENERAL	5.00		33. 11
33. 12	PATIENT PHONE DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		33. 12
33.16	SENI OR CI RCLE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33. 16
50.00	TOTAL (sum of lines 1 thru 49)		-14, 290, 659	1			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	PORTER MEMOR	REAL HOSPETAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2019 To 12/31/2019		nared
				10 12/31/2017	8/18/2020 12:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	0.00		1.00	5	
				4.00	5.00	
	A. COSTS INCURRED AND ADJUSTA HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	127, 703	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	698, 908	0	2.00
3.00		ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	8, 414, 385	0	3.00
4.00		CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	729, 098		4.00
4.01			PASI Capital Costs - Bldg &	82, 463		4.01
4.02		CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl			4.02
4.03		ADMINISTRATIVE & GENERAL	PASI Operating Costs	901, 863		4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	5, 578, 021	2, 662, 335	4.04
4.08	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	2, 112, 901	2, 628, 995	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	-7, 446, 221	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	5, 334, 105	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	5, 558	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	110, 606	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2, 397, 651	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	1, 051, 548	4.14
4.15			Contract Management	0	79, 310	4.15
4.16		ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe		189, 777	4.16
5.00	TOTALS (sum of lines 1-4).			18, 654, 038	8, 754, 708	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.		1			

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1.00	2.00	3.00	4.00	5.00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

6.00 B	0. 00 CHS	100.00 6.0
7.00	0.00	0.00 7.0
8.00	0.00	0.00 8.0
9.00	0.00	0.00 9.0
10.00	0.00	0.00 10.0
100.00 G. Other (financial or		100.0
non-financial) specify:		

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	PORTER MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	N RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0035	Period: From 01/01/2019	
			To 12/31/2019	Date/Time Prepared:

					8/18/2020 12:	:24 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ITS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					4
1.00	127, 703					1.00
2.00	698, 908					2.00
3.00	8, 414, 385					3.00
4.00	729, 098					4.00
4.01	82, 463					4.01
4.02	8, 696	9				4. 02
4.03	-839, 181	0				4.03
4.04	2, 915, 686	0				4.04
4.08	-516, 094	0				4.08
4.09	7, 446, 221	11				4.09
4.10	-5, 334, 105	0				4.10
4.11	-5, 558	0				4.11
4.12	-110, 606	0				4.12
4.13	-2, 397, 651	0				4.13
4.14	-1, 051, 548	0				4.14
4.15	-79, 310	0				4.15
4.16	-189, 777	0				4.16
5.00	9, 899, 330					5.00

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amounts decrease cost. For related organization or home office cost which

has no	t been posted to Worksheet A,	columns 1 and/or 2	2, the amount	allowable s	should be	i ndi cated	in column 4	of this part	
	Rel ated Organization(s)								
	and/or Home Office								
	Type of Business	1							
	51								
	6, 00	1							
		TED ODOANU ZATLONICO							-
	B. INTERRELATIONSHIP TO RELA	TED URGANIZATION(S	) AND/OR HOMI	E UFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00 HOME OFFICE	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
100.00	100.00
(1) Use the following symbols to indicate interrelationship to related organi	zations

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems	PORTER MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider C	CCN: 15-0035	Peri od:	Worksheet A-8	3-2
						From 01/01/2019		
						To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1, 126, 212	1, 126, 212	(	0 0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	2, 277, 408	2, 277, 408	(	o l	0	2.00
3,00	31.01	NEONATAL INTENSIVE CARE UNIT	760, 400	760, 400	(	o l	0	3, 00
4.00		OPERATI NG ROOM	3, 058, 608			0 0		
5.00		DELIVERY ROOM & LABOR ROOM	202, 750			0 0	-	5.00
6.00		ANESTHESI OLOGY	2, 114, 992				0	6,00
7.00		RADI OLOGY-DI AGNOSTI C	397, 387	397, 387			-	
8.00		ELECTROCARDI OLOGY					0	8.00
			3, 716, 052	3, 716, 052		-	0	
9.00		WOUND CARE	19, 800			0 0	0	9.00
10.00		ADMINISTRATIVE & GENERAL	1, 836			0 0	0	10.00
11.00	91.00	EMERGENCY	3, 577, 900			0 0	0	11.00
200.00			17, 253, 345	17, 253, 345		0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	(	0 0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	(	o l	0	2.00
3,00	31.01	NEONATAL INTENSIVE CARE UNIT	0			o lc	0	3,00
4,00	1	OPERATI NG ROOM	0	0		0 0	0	4,00
5.00		DELIVERY ROOM & LABOR ROOM	0			0 0	0	
6.00		ANESTHESI OLOGY	0	0		0 0	, s	
7.00		RADI OLOGY-DI AGNOSTI C	0	0				7.00
8.00		ELECTROCARDI OLOGY	0	0			0	
9.00		WOUND CARE	0	0			, s	9,00
			0				0	
10.00		ADMI NI STRATI VE & GENERAL	, s	0		-	0	10.00
11.00	91.00	EMERGENCY	0			0 0	, s	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adj ustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0			0 1, 126, 212		1.00
2.00	31.00	INTENSIVE CARE UNIT	0		(	2, 277, 408		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0			760, 400		3.00
4.00		OPERATING ROOM	0	0	(	3, 058, 608		4.00
5.00		DELIVERY ROOM & LABOR ROOM	0			202,750		5.00
6.00		ANESTHESI OLOGY	0			2, 114, 992		6.00
7.00		RADI OLOGY-DI AGNOSTI C	0			397, 387		7.00
8.00		ELECTROCARDI OLOGY	0			3, 716, 052		8.00
9.00		WOUND CARE	0			0 19,800		9,00
	1		0					
10.00	1	ADMI NI STRATI VE & GENERAL						10.00
11.00	91.00	EMERGENCY	0	0		3, 577, 900		11.00
200.00			0	0	(	0 17, 253, 345	I	200.00

Health Financial Systems	PORTER MEMORI				u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2019	Worksheet B Part I	
			Т	o 12/31/2019	Date/Time Pre 8/18/2020 12:	pared: 24 nm
		CAPI TAL REL	ATED COSTS	0, 10, 2020 12		
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)			1.00		
GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
1.00 00100 CAP REL COSTS-BLDG & FIXT	8, 077, 001	8, 077, 001				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	9, 719, 109		9, 719, 109			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	17, 331, 618 60, 030, 098	27, 153			42 004 017	4.00 5.00
7.00 00700 OPERATION OF PLANT	12, 399, 595	337, 434 1, 837, 620			62, 906, 017 16, 891, 241	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 417, 697	9, 730			1, 466, 449	8.00
9. 00 00900 HOUSEKEEPI NG	3, 303, 844	62, 866			3, 751, 873	
10. 00 01000 DI ETARY	1, 207, 502	198, 460			1, 803, 218	
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	1, 720, 861 3, 738, 320	0 35, 102	-		1, 940, 074 4, 477, 135	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 738, 320 1, 297, 247	137, 884			1, 768, 854	14.00
15. 00 01500 PHARMACY	3, 252, 377	75, 639			3, 992, 535	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 869, 925	26, 054			2, 060, 136	16.00
17.00 01700 SOCIAL SERVICE	1, 620, 127	2, 992	3, 670	278, 884	1, 905, 673	17.00
30. 00 03000 ADULTS & PEDIATRICS	18, 645, 795	1, 048, 441	1, 286, 047	3, 043, 873	24, 024, 156	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 726, 543	198, 348			7, 104, 777	31.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT	1, 740, 155	76, 677			2, 212, 932	1
41.00 04100 SUBPROVIDER - IRF	1, 316, 026	134, 933			1, 826, 912	41.00
43.00 04300 NURSERY	718, 971	24, 314	29, 824	112, 416	885, 525	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	14, 059, 044	666, 786	817, 899	1, 622, 862	17, 166, 591	50.00
51.00 05100 RECOVERY ROOM	0	0			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 451, 772	132, 714			3, 162, 327	52.00
53. 00 05300 ANESTHESI OLOGY	95, 254	11, 511	14, 119		120, 884	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	9, 181, 364	480, 783 0			11, 724, 006 0	54.00 54.01
56. 00 05600 RADI OL SOTOPE	0	0		-	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	-	0	58.00
	10, 934, 754	180, 182			12, 290, 960	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 339, 925 2, 280, 107	32, 425 139, 889			2, 783, 091 2, 979, 198	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	793, 705	0			941, 114	67.00
68.00 06800 SPEECH PATHOLOGY	635, 647	0			753, 447	68.00
69. 00 06900 ELECTROCARDI OLOGY	6, 100, 230	306, 464			7, 591, 249	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	2, 620, 168	0			2, 620, 168	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	18, 717, 623 28, 605, 895	0		0 24, 744	18, 717, 623 28, 630, 639	
74. 00 07400 RENAL DI ALYSI S	719, 949	6, 697	8, 214		734, 860	
76. 00 03950 ANCI LLARY	0	0	0	0	0	76.00
76.01 03610 SLEEP LAB	0	0	0	0	0	76.01
76. 03 03951 WOUND CARE OUTPATI ENT SERVICE COST CENTERS	1, 567, 761	69, 797	85, 615	168, 916	1, 892, 089	76.03
90. 00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	8, 658, 499	465, 252	570, 692	1, 241, 663	10, 936, 106	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	264, 894, 508	6, 726, 147	8, 250, 484	17, 378, 908	262, 061, 859	110 00
NONREI MBURSABLE COST CENTERS	204, 874, 508	0, 720, 147	0, 230, 484	17, 378, 908	202,001,039	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	76, 936	9, 801	12, 022	13, 170	111, 929	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	347	1, 187, 485	1, 456, 603		2, 644, 435	192.00
192. 01 19201 OTHER NONRELIMBURSABLE	0	0	0	0		192.01
194. 00 07950 NONREI MBURSABLE 194. 01 07951 MARKETI NG	0	0	0	0		194.00 194.01
194. 02 07952  SENI OR CI RCLE	0	0				194.01
194. 03 07953 OTHER NONRELMB COST C - REGENCY LTA	0	153, 568	0	0	153, 568	
194. 04 07954 VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00 Cross Foot Adjustments		_	_			200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	26/ 071 701	0 2 001	0 710 100	0 17 202 0		201.00
202.00  TOTAL (sum lines 118 through 201)	264, 971, 791	8, 077, 001	9, 719, 109	17, 392, 078	204, 971, 791	1202.00

	Financial Systems	PORTER MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 8/18/2020 12:	pared: 24 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	62, 906, 017					5.00
7.00	00700 OPERATION OF PLANT	5, 258, 497					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	456, 528	36, 684	1, 959, 661			8.00
9.00	00900 HOUSEKEEPI NG	1, 168, 014	237, 024	0	5, 156, 911		9.00
10.00	01000 DI ETARY	561, 369		0	176, 389	3, 289, 231	10.00
11.00	01100 CAFETERI A	603, 974		C	0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 393, 799			31, 198	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	550, 671	519, 865			0	14.00
15.00	01500 PHARMACY	1, 242, 936				0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY	641, 351	98, 232			0	16.00
17.00	01700 SOCIAL SERVICE	593, 265	11, 281		2, 659	0	17.00
30.00	03000 ADULTS & PEDIATRICS	7, 479, 080	3, 952, 937	791, 268	931, 839	1, 929, 220	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 211, 824				170, 354	
31.01	03101 NEONATAL INTENSIVE CARE UNIT	688, 919				19, 224	31.01
41.00	04100 SUBPROVIDER - IRF	568, 745				138, 283	
43.00	04300 NURSERY	275, 677				0	43.00
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	5, 344, 217	2, 513, 984	194, 352	592, 630	1, 926	
51.00	05100 RECOVERY ROOM	0	0	C		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	984, 480				31, 013	
53.00	05300 ANESTHESI OLOGY	37,633			10, 231	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 649, 859	1, 812, 696	213, 307	427, 313	1, 574	54.00
54.01	05401 ULTRASOUND	0	0		0	0	54.01
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0				0	56.00 57.00
58.00	05800 MRI	0				0	58.00
60.00	06000 LABORATORY	3, 826, 360	679, 339	333	160, 143	0	60.00
65.00	06500 RESPIRATORY THERAPY	866, 418				0	65.00
66.00	06600 PHYSI CAL THERAPY	927, 469				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	292, 983		C		0	67.00
68.00	06800 SPEECH PATHOLOGY	234, 559	0	C	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 363, 270	1, 155, 460	123, 329	272, 380	25, 695	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	815, 698	0	C	0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 827, 077	0	C	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 913, 057	0	C	0 0	0	73.00
74.00	07400 RENAL DIALYSIS	228, 773			5, 952	0	74.00
76.00	03950 ANCI LLARY 03610 SLEEP LAB	0	0		0	0	76.00
76.01	03951 WOUND CARE	589, 036	263, 156	42, 507	62,035	0	
70.03	OUTPATIENT SERVICE COST CENTERS	569,030	203, 130	42, 307	02,035	0	70.03
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	3, 404, 574	1, 754, 141	334, 584	413, 510	61, 768	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		.,				92.00
	SPECIAL PURPOSE COST CENTERS		1				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	62,000,112	17, 056, 613	1, 959, 661	3, 956, 290	2, 379, 057	118.00
	NONREI MBURSABLE COST CENTERS		-				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 845	36, 952	C	8, 711		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	823, 252	4, 477, 177	0	1, 055, 421	612, 173	
	19201 OTHER NONREI MBURSABLE	0	0	C	0 0		192.01
	07950 NONREI MBURSABLE	0	0	0	0		194.00
	07951 MARKETI NG	0	0				194.01
	07952 SENIOR CIRCLE 07953 OTHER NONREIMB COST C - REGENCY LTA	0			) 0 136, 489	0 298, 001	194.02
	07953 OTHER NONREIMB COST C - REGENCY LTA	47,808	578, 996		130,489		194.03 194.04
200.00		0			, 0	0	200.00
200.00		0	n –	0		n	200.00
201.00		62, 906, 017	22, 149, 738	1, 959, 661	5, 156, 911	3, 289, 231	
202.00		32,700,017	,, , , , , , , , , , , , , , ,	1 ., , , , , , , , , , , , , , , , , , ,	5,100,711	5,207,201	

Health Financial Systems	PORTER MEMORI		2N 15 0025		u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 8/18/2020 12:	pared: 24 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS           1.00         00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A	2, 544, 048					10.00
13. 00 01300 NURSING ADMINI STRATI ON	107, 362					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	61, 132			2		14.00
15. 00 01500 PHARMACY	73, 902			5, 675, 867		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	40, 975		66-		2, 864, 515	16.00
17.00 01700 SOCIAL SERVICE	45, 925	181, 342	20	8 0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	471.050	2 1/2 //0	152.01	4	222 ((0	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	471, 950 162, 884				222, 668 43, 575	
31.01 03101 NEONATAL INTENSIVE CARE UNIT	49,099				43, 575	
41. 00 04100 SUBPROVIDER - IRF	38, 258			-	12,074	
43. 00 04300 NURSERY	21, 173				5, 911	1
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	308, 911		332, 98		508, 376	
51.00 05100 RECOVERY ROOM	0	-		0 0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	78, 192	225, 835			21, 824	•
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	262, 579	144, 604	5, 92) 91, 52)		27, 247 350, 212	53.00 54.00
54. 01  05401  ULTRASOUND	202, 379			0 0	0	•
56. 00 05600 RADI OI SOTOPE		-		0 0	0	•
57.00 05700 CT SCAN	C	0		o o	0	57.00
58. 00 05800 MRI	C	0		0 0	0	58.00
60. 00 06000 LABORATORY	237, 319				314, 022	•
65. 00 06500 RESPI RATORY THERAPY	71, 313				74, 809	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	67, 682		.,	5 O 3 O	30, 381 16, 336	•
68. 00 06800 SPEECH PATHOLOGY	17, 365				6, 630	•
69. 00 06900 ELECTROCARDI OLOGY	140, 975				228, 486	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C				55, 766	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	1, 599, 63	4 0	257, 723	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 513	0		5, 675, 867	385, 151	•
74.00 07400 RENAL DIALYSIS	C			0 0	5, 725	•
76. 00 03950 ANCI LLARY 76. 01 03610 SLEEP LAB	C	0			0	
76. 03 03951 WOUND CARE	29,906	137, 619	12, 11			
OUTPATIENT SERVICE COST CENTERS	27,700	137,017	12,11		10, 044	/0.03
90. 00 09000 CLI NI C	C	0 0	(	0 0	0	90.00
91.00 09100 EMERGENCY	223, 179	919, 474	71, 56	4 0	260, 223	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS	0.507.04/		0.000.(1)		0.0(4.545	1
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 537, 346	6, 141, 839	3, 029, 61	2 5, 675, 867	2, 864, 515	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 702	0		0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0,702			0 0		192.00
192. 01 19201 OTHER NONREL MBURSABLE				0 0		192.01
194. 00 07950 NONREI MBURSABLE	C	-		0 0		194.00
194. 01 07951 MARKETI NG	C	0		0 0		194.01
194. 02 07952 SENI OR CI RCLE	C	0		0 0		194. 02
194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA	C	0		0 0		194.03
194. 04 07954 VACANT UNFLNI SHED AREA	C	0		0 0		194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers	-	_	.	o o		200.00
202.00 TOTAL (sum Lines 118 through 201)	2, 544, 048	6, 141, 839				
		1 3, 11, 337	1 0,027,01		2,001,010	

Heal th	Financial Systems	PORTER MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2552-10
COST A	LLOCATI ON - GENERAL SERVI CE COSTS		Provider C		riod: om 01/01/2019 12/31/2019	Worksheet B Part I Date/Time Prepared: 8/18/2020 12:24 pm
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-NVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
	01700 SOCIAL SERVICE	2, 740, 353				17.00
30. 00 31. 00 31. 01 41. 00	INPATI ENT ROUTI NE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	2, 100, 108 260, 862 124, 465 138, 774 116, 144	44, 218, 880 11, 771, 220 3, 761, 659 3, 537, 358 1, 422, 532	0 0 0	44, 218, 880 11, 771, 220 3, 761, 659 3, 537, 358 1, 422, 532	30. 00 31. 00 31. 01 41. 00 43. 00
	ANCI LLARY SERVICE COST CENTERS					
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 01\\ 76.\ 03\\ 90.\ 00\\ \end{array}$	ANGLELART SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05401 ULTRASOUND 05600 RADIOLOGY-DIAGNOSTIC 05600 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MRI 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 ANCILLARY 03610 SLEEP LAB 03951 WOUND CARE 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09100 EMERGENCY		27, 867, 142 0 5, 194, 876 245, 320 18, 677, 676 0 0 17, 837, 779 3, 971, 967 4, 672, 957 1, 275, 188 1, 012, 001 12, 379, 077 3, 666, 731 26, 402, 057 43, 667, 227 1, 000, 559 0 0 3, 044, 003 0 18, 379, 123		27, 867, 142 0 5, 194, 876 245, 320 18, 677, 676 0 0 17, 837, 779 3, 971, 967 4, 672, 957 1, 275, 188 1, 012, 001 12, 379, 077 3, 666, 731 26, 402, 057 43, 607, 227 1, 000, 559 0 3, 044, 003	50.00 51.00 52.00 53.00 54.01 56.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 74.00 76.03 90.00 91.00
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS			0		92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 740, 353	253, 945, 332	0	253, 945, 332	118.00
192.00 192.01 194.00 194.01 194.02 194.03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRIVATE OFFICES 19201 OTHER NONREI MBURSABLE 07950 NONREI MBURSABLE 07951 MARKETI NG 07952 SENI OR CI RCLE 07953 OTHER NONREI MB COST C - REGENCY LTA 07954 VACANT UNFI NI SHED AREA		199, 139 9, 612, 458 0 0 0 0 1, 214, 862	0 0 0 0 0	199, 139 9, 612, 458 0 0 0 1, 214, 862 0	190.00 192.00 192.01 194.00 194.01 194.02 194.03 194.03
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers	0 0 2, 740, 353	0 0 0 264, 971, 791	0 0 0 0	0 0 264, 971, 791	194. 04 200. 00 201. 00 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	PORTER MEMORI	Provider C	CN: 15-0035 Pe	eriod:	u of Form CMS-: Worksheet B	2552-10
112200/11					rom 01/01/2019	Part II Date/Time Pre 8/18/2020 12:	pared:
			CAPI TAL REL	ATED COSTS		0/10/2020 12.	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	ľ	Γ				
	00100 CAP REL COSTS-BLDG & FIXT						1.00 2.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	27, 153	33, 307	60, 460	60, 460	1
	00500 ADMI NI STRATI VE & GENERAL	0	337, 434	413, 906	751, 340	7, 384	
	00700 OPERATION OF PLANT	0	1, 837, 620		4, 091, 698	1, 390	
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 730	11, 935	21, 665	94	8.00
	00900 HOUSEKEEPI NG	0	62, 866	77, 113	139, 979	1, 071	9.00
	01000 DI ETARY	0	198, 460	243, 437	441, 897	535	
		0	0	0	0	762	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	35, 102 137, 884	43, 057 169, 133	78, 159 307, 017	2, 296 572	
	01400 CENTRAL SERVICES & SUPPLY	0	75, 639		168, 420	1, 987	
	01600 MEDICAL RECORDS & LIBRARY	0		31, 959	58, 013	459	
	01700 SOCIAL SERVICE	0		3, 670	6, 662	969	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0		1, 286, 047	2, 334, 488	10, 591	30.00
	03100 I NTENSI VE CARE UNI T	0	198, 348		441, 648	3, 255	
	03101 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0	76, 677 134, 933	94, 054 165, 512	170, 731 300, 445	1, 050 731	31.01
	04300 NURSERY	0		29, 824	54, 138	391	41.00
	ANCI LLARY SERVI CE COST CENTERS	0	24, 314	27,024	54, 150	571	40.00
	05000 OPERATING ROOM	0	666, 786	817, 899	1, 484, 685	5, 641	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	132, 714	162, 791	295, 505	1, 443	
	05300 ANESTHESI OLOGY	0	11, 511	14, 119	25, 630	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	480, 783	589, 742 0	1, 070, 525	5, 117	54.00 54.01
	05600 RADI OI SOTOPE	0			0	0	56.00
	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MRI	0	0	0	0	0	58.00
	06000 LABORATORY	0	180, 182	221, 016	401, 198	3, 319	
	06500 RESPI RATORY THERAPY	0	32, 425	39, 774	72, 199	1, 289	
	06600 PHYSI CAL THERAPY	0	139, 889	171, 592	311, 481	1, 347	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	512	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	306, 464	0 375, 917	0 682, 381	409 2, 811	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	373, 717	002, 301	2,011	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	86	73.00
	07400 RENAL DIALYSIS	0	6, 697	8, 214	14, 911	0	
	03950 ANCI LLARY	0	0	0	0	0	
	03610 SLEEP_LAB 03951 WOUND_CARE	0	0	05 (15	155 410	0	
-	OUTPATIENT SERVICE COST CENTERS	0	69, 797	85, 615	155, 412	587	76.03
	09000 CLINIC	0	0	0	0	0	90.00
	09100 EMERGENCY	0		570, 692	1,035,944	4, 316	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
-	SPECIAL PURPOSE COST CENTERS		L				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 726, 147	8, 250, 484	14, 976, 631	60, 414	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 801	12 022	21 022	A /	190.00
	19200 PHYSICIANS' PRIVATE OFFICES		9, 801 1, 187, 485	12, 022 1, 456, 603	21, 823 2, 644, 088		190.00
	19200 OTHER NONREI MBURSABLE	n 0	0	1, 400, 000	2, 044, 000 N		192.00
	07950 NONREI MBURSABLE	0	0	0	0		194.00
194.01	07951 MARKETI NG	0	0	0	0	0	194.01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
	07953 OTHER NONREIMB COST C - REGENCY LTA	0	153, 568	0	153, 568		194.03
	07954 VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00 201.00	Cross Foot Adjustments Negative Cost Centers		_		0	0	200.00
201.00	TOTAL (sum lines 118 through 201)	0	8, 077, 001	0 9, 719, 109	0 17, 796, 110		
202.00	TOTAL (Sum TIMES THE UNDUGH ZUT)	ı 0	0,077,001	7, 717, 109	17,770,110	00, 400	1202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	PORTER MEMORI	Provider C		Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet B Part II Date/Time Pre 8/18/2020 12:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1		1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	758, 724					5.00
7.00	00700 OPERATION OF PLANT	63, 427	4, 156, 515				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 507	6, 884	34, 15	0		8.00
9.00	00900 HOUSEKEEPI NG	14, 088	44, 479		0 199, 617		9.00
10.00	01000 DI ETARY	6, 771	140, 414		0 6, 828	596, 445	10.00
11.00	01100 CAFETERI A	7, 285	0		0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	16, 812	24, 835		0 1, 208	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	6, 642				0	14.00
15.00	01500 PHARMACY	14, 992	53, 516			0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	7,736			0 896	0	16.00
17.00	01700 SOCIAL SERVICE	7, 156	2, 117		0 103	0	17.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.011	744 700	10.70	al a a a a a	0.40,004	
30.00	03000 ADULTS & PEDIATRICS	90, 211				349, 831	30.00
31.00	03100 I NTENSI VE CARE UNI T	26, 678				30, 891	31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT	8, 310				3, 486	31.01
41.00	04100 SUBPROVIDER - IRF	6, 860				25, 075	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 325	17, 203	1	0 836	0	43.00
50.00	05000 OPERATING ROOM	64, 461	471, 762	3, 38	7 22, 940	349	50.00
51.00	05100 RECOVERY ROOM	0,401	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 875	-			5, 624	52.00
53.00	05300 ANESTHESI OLOGY	454			0 396	0,021	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	44,024				285	54.00
54.01	05401 ULTRASOUND	0	0		0 0	0	54.01
56.00	05600 RADI OI SOTOPE	0	0		o o	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MRI	0	0		0 0	0	58.00
60.00	06000 LABORATORY	46, 153	127, 482		6 6, 199	0	60.00
65.00	06500 RESPI RATORY THERAPY	10, 451	22, 941		0 1, 116	0	65.00
66.00	06600 PHYSI CAL THERAPY	11, 187	98, 974			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 534			0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2, 829			0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	28, 505				4, 659	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	9,839	0		0 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	70, 285	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	107, 471	0		0 0	0	73.00
	07400 RENAL DIALYSIS	2, 759		1	0 230	0	74.00
76. 00 76. 01	03950 ANCI LLARY 03610 SLEEP LAB	0	0		0 0 0 0	0	76.00 76.01
	03951 WOUND CARE	7, 105				0	
70.03	OUTPATIENT SERVICE COST CENTERS	7,105	49, 383	/4	2,401	0	70.03
90.00	09000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	41,065	329, 174	5, 83			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	11,000	027,171	0,00	10,000	11,201	92.00
/2:00	SPECIAL PURPOSE COST CENTERS						/2/00
118.00		747, 797	3, 200, 763	34, 15	0 153, 142	431, 401	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	6, 934		0 337	0	190.00
190.00		9,930			0 40, 855	111, 007	192.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	7,730				0	192.01
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 OTHER NONREI MBURSABLE	9, 930	0		0 0	0	192.01
192.00 192.01 194.00	19201 OTHER NONREI MBURSABLE 07950 NONREI MBURSABLE	0	0		0 0		192.01
192.00 192.01 194.00 194.01	19201 OTHER NONREI MBURSABLE 07950 NONREI MBURSABLE 07951 MARKETI NG	0 0 0	0 0 0		0 0 0 0 0 0	0 0	194. 00 194. 01
192.00 192.01 194.00 194.01 194.02	19201 OTHER NONREI MBURSABLE 07950 NONREI MBURSABLE 07951 MARKETI NG 07952 SENI OR CI RCLE	0 0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0	194. 00 194. 01 194. 02
192.00 192.01 194.00 194.01 194.02 194.03	19201 OTHER NONREIMBURSABLE 07950 NONREIMBURSABLE 07951 MARKETING 07952 SENIOR CIRCLE 07953 OTHER NONREIMB COST C - REGENCY LTA	0 0 0 0 0 0 577	0 0 0 108, 652		0 0 0 0 0 0 0 0 0 0 0 5, 283	0 0 54, 037	194. 00 194. 01 194. 02 194. 03
192.00 192.01 194.00 194.01 194.03 194.03 194.04	19201 OTHER NONREIMBURSABLE 07950 NONREIMBURSABLE 07951 MARKETING 07952 SENIOR CIRCLE 07953 OTHER NONREIMB COST C - REGENCY LTA 07954 VACANT UNFINISHED AREA	0 0 0 0	0 0 0 108, 652 0		0 0 0 0 0 0	0 0 54, 037	194.00 194.01 194.02 194.03 194.04
192.00 192.01 194.00 194.01 194.03 194.03 194.04 200.00	19201 OTHER NONREIMBURSABLE 07950 NONREIMBURSABLE 07951 MARKETING 07952 SENIOR CIRCLE 07953 OTHER NONREIMB COST C - REGENCY LTA 07954 VACANT UNFINISHED AREA Cross Foot Adjustments	0 0 0 0	0 0 0 108, 652 0		0 0 0 0 0 0	0 0 54, 037 0	194.00 194.01 194.02 194.03 194.04 200.00
192.00 192.01 194.00 194.01 194.03 194.03 194.04	19201 OTHER NONREIMBURSABLE 07950 NONREIMBURSABLE 07951 MARKETING 07952 SENIOR CIRCLE 07953 OTHER NONREIMB COST C - REGENCY LTA 07954 VACANT UNFINISHED AREA Cross Foot Adjustments Negative Cost Centers	0 0 0 0	0		0 0 0 0 0 5, 283 0 0 0 0	0 0 54, 037 0	194. 00 194. 01 194. 02 194. 03 194. 04 200. 00 201. 00

	F CAPITAL RELATED COSTS	PORTER MEMORI	Provi der CC	F	veriod: rom 01/01/2019 o 12/31/2019	u of Form CMS-2 Worksheet B Part II Date/Time Prep	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	8/18/2020 12: MEDI CAL RECORDS & LI BRARY	24 pm
		11.00	13.00	14.00	15.00	16.00	
	L SERVICE COST CENTERS				,		
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
1 1	EMPLOYEE BENEFITS DEPARTMENT						4.00
1 1	ADMINISTRATIVE & GENERAL						5.00
	OPERATION OF PLANT						7.00
	LAUNDRY & LINEN SERVICE						8.00
1 1	HOUSEKEEPING						9.00
	DIETARY	0.047					10.00
		8,047	400 (50				11.00
	NURSI NG ADMI NI STRATI ON	340	123, 650	41 ( 007			13.00
	CENTRAL SERVICES & SUPPLY	193	0	416, 837	1 1		14.00
1 1		234	0	01		05 750	15.00
1 1	MEDICAL RECORDS & LIBRARY	130	2 (51	91	1	85, 759	•
	SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	145	3, 651	29	0	0	17.00
	ADULTS & PEDIATRICS	1, 492	43, 529	21, 081	0	6, 727	30.00
	INTENSIVE CARE UNIT	515					
	NEONATAL INTENSIVE CARE UNIT	155	14, 340 5, 293	7, 539	1 1	1, 316	1
	SUBPROVIDER - IRF	121	3, 036	1, 241 727	1	660 365	•
	NURSERY	67	3,030	663		179	•
	ARY SERVICE COST CENTERS	07	0	003	0	1/9	43.00
	OPERATING ROOM	977	18, 185	45, 816	0	14, 576	50.00
	RECOVERY ROOM	0	10, 105	45, 810	-	14, 370	51.00
	DELIVERY ROOM & LABOR ROOM	247	4, 547	2, 712	-	659	•
	ANESTHESI OLOGY	0	4, 347	815		823	53.00
	RADI OLOGY-DI AGNOSTI C	831	2, 911	12, 593		10, 580	
	ULTRASOUND	0	2, 711	12, 373		0, 500	54.00
	RADI OI SOTOPE	0	0		-	0	•
1 1	CT SCAN	0	0		0	0	57.00
58.00 05800		0	0		0	0	58.00
	LABORATORY	751	0	45, 309	-	9, 487	•
	RESPI RATORY THERAPY	226	0	3, 476		2, 260	•
	PHYSI CAL THERAPY	214	0	228	1	918	•
	OCCUPATIONAL THERAPY	78	0	0		494	
	SPEECH PATHOLOGY	55	0		0	200	•
	ELECTROCARDI OLOGY	446	6, 874	18, 825	0	6, 903	•
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	24, 092	0	1, 685	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	220, 087	1 1	7, 786	•
73.00 07300	DRUGS CHARGED TO PATIENTS	8	0	C	241, 996	11, 636	73.00
74.00 07400	RENAL DI ALYSI S	0	0	C	0	173	74.00
76.00 03950	ANCILLARY	0	0	C	0	0	76.00
76.01 03610	SLEEP LAB	0	0	C	0	0	76.01
76.03 03951		95	2, 771	1, 666	0	470	
OUTPAT	IENT SERVICE COST CENTERS						1
90.00 09000	CLINIC	0	0	C	0	0	90.00
91.00 09100	EMERGENCY	706	18, 513	9, 847	0	7, 862	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECI A	L PURPOSE COST CENTERS						]
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 026	123, 650	416, 837	241, 996	85, 759	118.00
NONREL	MBURSABLE COST CENTERS						]
190.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21	0	C	0	0	190.00
	PHYSICIANS' PRIVATE OFFICES	0	0	C	0		192.00
	OTHER NONREI MBURSABLE	0	0	C	0		192. 01
	NONREIMBURSABLE	0	0	C	0		194.00
	MARKETI NG	0	0	C	0	0	194. 01
194.0107951	SENLOR CLECLE	0	0	C	0	0	194. 02
194. 01 07951 194. 02 07952	SERVICE STREET					- 1	1
194.0207952	OTHER NONREIMB COST C - REGENCY LTA	0	0		0		194.03
194. 02 07952 194. 03 07953		0	0			0	194.04
194. 02 07952 194. 03 07953 194. 04 07954 200. 00	OTHER NONREIMB COST C - REGENCY LTA VACANT UNFINISHED AREA Cross Foot Adjustments	0	0	C	0	0	194. 04 200. 00
194. 02 07952 194. 03 07953 194. 04 07954 200. 00 201. 00	OTHER NONREIMB COST C - REGENCY LTA VACANT UNFINISHED AREA	0 0 0 8, 047	0 0 123, 650		0 0 0 241, 996	0	194. 04 200. 00 201. 00

	nancial Systems DN OF CAPITAL RELATED COSTS	PORTER MEMORIA		CN: 15-0035	Period:	u of Form CMS-255 Worksheet B
					From 01/01/2019 To 12/31/2019	Part II
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		17.00	24.00	25.00	26.00	
-	NERAL SERVICE COST CENTERS	1		Т		
. 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           . 00         00           1. 00         01	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 000 DI ETARY 100 CAFETERIA 300 NURSING ADMINISTRATION					1 1 1
4. 00015. 00016. 00017. 0001	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE PATIENT ROUTINE SERVICE COST CENTERS	20, 832				1: 1: 1: 1: 1:
	000 ADULTS & PEDI ATRI CS	15, 965	3, 665, 564	l I	0 3, 665, 564	3
1.00 03	100 INTENSIVE CARE UNIT	1, 983	677, 516		0 677, 516	3
	101 NEONATAL INTENSIVE CARE UNIT	946	249, 039		0 249, 039	3
	100 SUBPROVIDER - IRF	1, 055	439, 039		0 439, 039	4
	300 NURSERY CI LLARY SERVI CE COST CENTERS	883	77, 685		0 77,685	4
	000 OPERATI NG ROOM	0	2, 132, 779		0 2, 132, 779	5
	100 RECOVERY ROOM	0	2, 132, 77		0 2,132,777	5
	200 DELIVERY ROOM & LABOR ROOM	0	422, 001		0 422,001	5
	300 ANESTHESI OLOGY	0	36, 262		0 36, 262	5
	400 RADI OLOGY-DI AGNOSTI C	0	1, 507, 286	þ	0 1, 507, 286	5
	401 ULTRASOUND	0	(	D	0 0	5
	600 RADI OI SOTOPE	0	(		0 0	5
	700 CT SCAN 800 MRI	0	(		0 0	5
	000 LABORATORY	0	639, 904	L	639,904	6
	500 RESPI RATORY THERAPY	0	113, 958		0 113, 958	6
	600 PHYSI CAL THERAPY	0	429, 420		0 429, 420	6
7.00 06	700 OCCUPATIONAL THERAPY	0	4, 618	3	0 4, 618	6
	800 SPEECH PATHOLOGY	0	3, 493	3	0 3, 493	6
	900 ELECTROCARDI OLOGY	0	980, 924		0 980, 924	6
	100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	35, 616		0 35, 616	7
	200 I MPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	298, 158		0 298, 158 0 361, 197	7.
	400 RENAL DIALYSIS	0	361, 197 22, 811		0 361, 197 0 22, 811	7
	950 ANCI LLARY	0	22,011		0 0	7
	610 SLEEP LAB	0	(		0 0	7
. 03 03	951 WOUND CARE	0	220, 631		0 220, 631	7
	TPATIENT SERVICE COST CENTERS	1		T	-	
		0	1 400 445		0 0	9
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 480, 465		0 1, 480, 465 0	9
	ECIAL PURPOSE COST CENTERS			I	<u> </u>	9.
8.00	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	20, 832	13, 798, 366		0 13, 798, 366	11
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 581		0 29, 581	19
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 646, 046		0 3, 646, 046	19
	201 OTHER NONREI MBURSABLE	0	(		0 0	19.
	950 NONREI MBURSABLE	0	(		0 0	19
	951 MARKETI NG	0	(	2	0 0	19
	952 SENIOR CIRCLE 953 OTHER NONREIMB COST C - REGENCY LTA	0	322, 117	7	0 322, 117	19 19
	953 VACANT UNFINISHED AREA	0	322, 117		0 322, 117	19
04.0407	Cross Foot Adjustments		(		0 0	20
01.00	Negative Cost Centers	О	(	þ	0 0	20
	TOTAL (sum lines 118 through 201)	20, 832	17, 796, 110	1	0 17, 796, 110	20.

From 01/01/2018 To 12/31/2018         Duto This is provided in the second in the s		u of Form CMS- Worksheet B-	In Lie eriod:	N: 15-0035 P	AL HOSPITAL Provider CC	PORTER MEMORI	th Financial Systems ALLOCATION - STATISTICAL BASIS	
Cost Center Description         CAPITAL RELATED COSTS BLOG & FLXT         Description         Description <thdescription< th=""></thdescription<>			rom 01/01/2019	F				
Cost Center Description         BLDG & FIXT (SQUARE FEET) (DOLLAR VALUE) ENPRTEENT COULAR VALUE)         Reconciliation BENETIS COULAR VALUE) (ACCUM. COST)           EFNERAL SERVICE COST CENTERS         1.00         2.00         4.00         5A         5.00           0         00000 QAP REL COSTS BLDE & FIXT 000001 QAP NEL COSTS SUBJER & FIXT 0000001 QAP NEL COSTS SUBJER & FIXT 0000000 PETARY         135, 553         100, 650, 672, 623         200, 000, 017, 020, 02, 020, 023           10.000000 FITARY         11, 80, 91, 91, 91, 91, 484         13, 544         12, 80, 702         2, 80, 702         2, 80, 702         2, 92, 73         1, 768, 59           10.000000 FITARY         12, 444         13, 444         13, 945         1, 936, 713         1, 768, 92           10.00000 COLLETER IA         0, 10000 CAP NEL COST CENTERS         1, 946, 713         1, 9	<u>20 12:24 pm</u>	8/18/2020 12:			ATED COSTS	CAPI TAL REI		
COURT         COULAR VALUE (ACCUM. COST)         DEPARTMENT (CROSS)         A CENERAL (ACCUM. COST)           0         DIODO LAR PLE LOSTS AUGA E TAT (CROSS)         1.00         2.00         4.00         5A         5.00           1.00         DIODO LAR PLE LOSTS AWGB E FOLIP B COORD ADD PLAYE E BERNET IS DEPARTMENT (CROSS)         773, 617         778, 528         77.229, 066         7.229, 066         7.229, 066         7.229, 066         7.220, 066, 07         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.71         7.544, 991         0.3         7.51, 47           1.00         DIOSC LAURDRY & LINEN SERVICE         956         956         130, 533         0         1.406, 44         7.401         0         7.71, 401         0         7.71, 401         0         7.802, 001         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.903, 713, 01         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 440         1.909, 441         1.909, 440	AT11/E							
Control Contend Control Control Control Control Control Control			Reconciliation				Cost Center Description	
ELNERAL SERVICE COST CENTERS         South Cost Centers           0         000100 GAP REL_COSTS-BLD6 & FIXT         793,617         778,528         778,528           2.00         000500 GAP REL_COSTS-WUELE EQUIP         778,528         87,228,066         778,528           5.00         005500 ADDI INSTRATIVE & GEMERAL         33,155         10,555,609         -62,906,017         202,065,77           5.00         005500 ADDI INSTRATIVE & GEMERAL         33,155         10,585,609         -62,906,017         202,065,77           5.00         005500 ADDI INSTRATIVE & GEMERAL         33,155         10,690         11,460,44         1,460,44           9.00         09900 HOUSEKEPING         6,177         6,177         1,744,49         0         3,751,67           10.00         01000 CAFETERIA         0         0         0         1,906,77         1,968,73         0         1,906,77           10.00         01000 CHARAKCY         2,342         7,432         7,432         7,432         2,843,931         0         1,906,77           10.00         01000 MESI KA ADRINI STRATI ON         3,449         3,313,451         0         1,905,77         1,905,77         1,905,77         1,905,77         1,905,77         1,905,77         1,905,79         1,905,79		(ACCUM. COST)		DEPARTMENT	()	(		
ENERAL SERVICE COST CENTERS         1.00         2.00         4.00         5A         5.00           1.00         00100 CAP REL COSTS-BL0.6 A FIXT         778, 528         778, 548 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
1.00         00100 CAP ELL COSTS-BUDE & FIXT         778, 517           2.00         00200 CAP HEL COSTS-MURLE BUPLP         778, 528           4.00         00400 EWPLOYEE BENEFITS DEPARTMENT         2, 668         22, 666           50.00         00500 OPERATION OF PLANT         180, 558         10, 655, 609         -62, 906, 017           7.00         00700 OPERATION OF PLANT         180, 558         130, 558         135, 653         0         1, 466, 449           9.00         00900 HOUSEKEEPI NG         6, 177         6, 177         6, 177         1, 460, 449         3, 313, 451         0         1, 460, 449           9.00         10100 CAF FIERA         0         0         0         1, 999, 440         1, 490, 07           11         00         10100 CAF FIERA         0         0         0         1, 263, 21           11         00         1000 MISIN SI ADUIN ISTRATION         3, 444         3, 449         3, 313, 451         0         1, 260, 25           11         00         1000 KISIN SA ADUIN ISTRATION         3, 448         3, 449         2, 260, 33         0         1, 260, 25           11         0.00         3000 ADULTS & FENOREC SA SUPLY         1, 342         2, 264         1, 260, 25         1, 160, 114	)	5.00	5A		2.00	1.00		
2.00 00200 CAP REL COSTS-AVUEL E GUI P 778, 528 7728, 066 705 00500 ADMINISTRATI VE & GENERAL 33, 155 33, 155 10, 655, 609 -62, 906, 017 202, 065, 77 70 00700 OPERATI NO TO PLANT 180, 558 180, 558 22, 055, 899 16, 891, 24 8, 00 00800 LAUMORY & LINEN SERVICE 956 956 173 7, 15, 44, 991 0, 3, 751, 87 10, 00 1000 DIETARY 1010 CAFTERI A 0 0 1, 1, 99, 400 1, 1, 803, 711, 80 1, 100 01100 CAFTERI A 0 0 0, 1, 99, 400 1, 1, 803, 713, 87 1, 80 1, 00 1, 000 CAFTERI A 0 0 0, 1, 994, 40 0, 1, 940, 07 13, 00 01300 DIETARY 17, 451 13, 548 13, 548 225, 483 0, 1, 768, 85 15, 00 01300 MURSI NG ADMINISTRATION 3, 444 3, 449 3, 449 3, 313, 451 0, 4, 477, 13, 40 0140, 00 FLINAL SERVICES A SUPPLY 13, 548 13, 548 225, 483, 40 1, 768, 85 15, 00 01500 PARAMACY 7, 7, 432 7, 432 7, 432 2, 867, 492 0, 3, 992, 53 10, 01500 PARAMACY 17, 7, 540 10, 01100 SOCI AL, SERVICE 0 OST CENTERS 0 10 0100 MURSI NE FARUITE SUPPLY 13, 548 13, 549 225, 461, 90 1, 90, 500 11, 905, 57 1, 90 1, 905, 57 1, 90 1, 905, 57 1, 90 1, 905, 71 3, 0 1, 905, 57 1, 90 10100 SOCI AL, SERVICE 0 OST CENTERS 0 1 00 1000 MURSI & PEDIATIRICS 103, 904, 90 469 103, 016 152, 665, 169 24, 024, 15 100, 01000 MURSI & PEDIATIRICS 103, 904, 90 469 103, 469 4, 697, 583 0, 2, 7, 704, 7, 100 1100 INFRMATA LINFENSIVE CARE UNIT 7, 754 7, 7554 7, 7554 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 754 7, 755 7, 754 7, 755 7, 754 7, 754 7, 755 7, 755 7, 754 7, 755 7, 754 7, 755 7, 755 7, 754 7, 7								
4.00         00400 FMPLOVEE BENEFITS DEPARTMENT         2,668         2,668         2,28,060	1.00					793, 617		
5.00         00500 ADMINISTRATIVE & GENERAL         33, 155         33, 155         33, 155         22, 005, 007         -62, 906, 017         202, 005, 77           8.00         00600 LAUMDRY & LINEN SERVICE         956         956         135, 853         0         1, 466, 491, 24           9.00         00600 LAUMDRY & LINEN SERVICE         956         956         177         1, 544, 991         0         3, 751, 87           10.00         01000 DIETARY         19, 500         19, 500         1, 097, 441         0         1, 803, 21           13.00         01300 NURSING ADMINISTRATION         3, 449         3, 449         3, 449         3, 313, 451         0         4, 477, 13           14.00         01400 CENTRAL SERVICES & SUPPLY         13, 546         13, 546         825, 463         0         1, 768, 65           15.00         01500 PHARMACY         7, 432         7, 432         2, 867, 492         0         2, 996, 57           17.00         01300 ADULTS & PEDIATRICS         103, 016         103, 016         103, 016         103, 016         1, 995, 57           17.00         01300 ADULTS & PEDIATRICS         103, 016         17, 154, 881         0         2, 212, 93           0.00         03000 ADULTS & PEDIATRICS         103, 11, 13	4.00			87, 228, 066		2, 668		
8.00         000000         LAUDERY & LINEN SERVICE         9956         9966         135, 653         0         1, 466, 44, 991           9.00         00000 DUESKEPING         6, 177         6, 177         1, 544, 4991         0         3, 751, 87           10.00         01000 DUE TARY         19, 500         19, 500         0         0, 994, 400         0         1, 490, 44, 991           13.00         01300 NURSING ADMINI STRATION         3, 449         3, 443         3, 313, 451         0         4, 477, 13           14.00         01400 CENTRAL SERVICES & SUPPLY         13, 548         13, 548         63, 024         0         3, 992, 53           17.00         01500 PHARMACY         2, 560         2, 560         663, 024         0         1, 995, 71           17.00         03000 ADULTS & PEDIATRICS         103, 016         103, 016         15, 266, 119         0         2, 402, 15           10.0         03000 ADULTS & PEDIATRICS         103, 316         15, 265, 417         0         1, 226, 91           11.00         04300 NIRSERV         2, 389         2, 389         5, 313         0         7, 104, 77           13.00         04300 NIRSERV         2, 389         2, 389         563, 813         0         85, 5477 </td <td></td> <td>202, 065, 774</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		202, 065, 774						
9.00 00900 HUSEKEEPING 6,177 6,177 6,177 4,44,991 0,3,751,87 10.00 01000 LFTARY 19,500 1771,461 0,1,903,21 11.00 01100 CAFETERIA 10 0,1000 KRS1NG ADMINISTRATION 3,449 9,304,34,49 3,31,451 0,477,13 14.00 01400 CENTRAL SERVICES & SUPPLY 13,548 13,548 235,483 0,1,768,85 15.00 01500 HABMACY 2,7,432 2,560 2,560 2,560 663,024 0,2,060,13 16.00 01400 KEDICAL RECORDS & LI BRARY 2,550 2,560 4,63,024 0,2,060,13 10.00 0300 INTENSINE CARE UNIT 19,489 19,489 19,489 17,33 0,1,995,67 10.00 0300 INTENSIVE CARE UNIT 19,489 19,489 19,467,353 0,7,104,77 10.00 0300 INTENSIVE CARE UNIT 7,534 7,534 1,514,881 0,2,212,93 11.00 03100 INTENSIVE CARE UNIT 7,534 7,534 1,514,881 0,2,212,93 11.00 05100 REPARTING SERVICE COST CENTERS 10.00 05000 DEFARTING SERVICE COST CENTERS 10.00 5100 DEFARTING NEW CARE UNIT 7,754 1,514 4,813 0,212,93 11.00 04100 SUBPROVI DER - IREF 13,258 13,258 13,258 13,258 13,258 13,258 13,258 10,055,447 0,1,826,91 11.00 05100 REPARTING NEOM 16,000 11,7,166,55 16 0,139,299 0,17,166,55 10,00 0,17,166,55 10,00 0,17,166,55 10,00 0,17,166,55 10,00 0,17,166,55 10,00 0,17,166,55 10,00 0,17,166,55 10,00 0,00 0,17,166,55 10,00 0,00 0,17,166,55 0,10 0,00 0,17,166,55 0,10 0,00 0,17,166,55 0,10 0,00 0,00 0,17,166,55 0,10 0,00 0,11,7,24,00 0,00 0,10 0,17,166,55 0,10 0,00 0,11,7,24,00 0,00 0,11,7,24,00 0,00 0,11,7,24,00 0,00 0,10 0,10,10,10,10,10,10,10,10,10,10,10,10,10								
10. 00       01000       D (19, 500       19, 500       01, 90, 9400       01, 100, 100, 100, 04ETERN         13. 00       01300       NURSING ADMINISTRATION       3, 449       3, 449       3, 313, 451       0       4, 477, 13         13. 00       01300       NURSING ADMINISTRATION       3, 548       13, 548       825, 483       01, 1768, 85         15. 00       01500       PHABMACY       7, 432       7, 432       7, 432       2, 667, 492       0, 3992, 55         17. 00       SOCIAL_SERVICE       294       294       1, 996, 713       0       1, 905, 67         10. 00       SOCIAL_SERVICE       294       294       1, 398, 713       0       2, 402, 15         10. 00       03000       INTERSIVE CARE UNIT       19, 489       19, 469       1, 667, 7353       0       2, 212, 93         11. 00       03101       INEDIATIC COST CENTERS       2, 389       2, 381       1, 655, 441       0       1, 22, 212, 93         10. 01 400 OPERATING ROM       65, 516       65, 516       8, 139, 299       0       17, 166, 59         10. 00 5100 OPERATING ROM       65, 516       65, 516       8, 139, 299       0       17, 166, 59         20. 00 55200 OPENATING ROM & LABOR ROM       13, 040       <								
11. 00     01 100 (AFETERIA     0     0     1, 099, 440     0     1, 494, 07       13. 00     01 400 (UNISI KG ADM INI STRATION     3, 449     3, 313, 451     0     4, 477, 131       14. 00     01 400 (ENTRAL, SERVI CE, & SUPPLY     13, 548     13, 548     825, 483     0     1, 768, 85       15. 00     01 600 (HEID CAL, RECORDS & LI BRARY     2, 560     2, 560     2, 663, 024     0     2, 060, 13       10. 00     000 (300 ANULTS, & PEDI ATRI CS     103, 016     15, 266, 119     0     2, 402, 415       10. 00     300 (AJOD ANULTS, & PEDI ATRI CS     103, 016     15, 266, 119     0     2, 402, 415       11. 00     03 100 (INTERNI VE CARE UNI T     7, 534     1, 514, 881     0     2, 212, 93       11. 00     04 100 SUBRROVI DER - LIRF     13, 258     13, 258     1, 514, 881     0     2, 212, 93       10. 00 500 DER VERY ROM     65, 516     65, 516     8, 139, 299     0     17, 166, 55, 52       10. 00 500 DER VERY ROM     13, 040     2, 081, 640     0     3, 162, 53       20. 00 5200 DELI VERY ROM A LABOR ROOM     13, 040     2, 081, 640     0     162, 28       23. 00 5200 DELI VERY ROM A LABOR ROOM     13, 040     2, 081, 640     0     0       24. 00 5400 DELI VERY ROM A LABOR ROOM     13,								
14.00       O1400       CENTRAL SERVICES & SUPPLY       13,548       13,548       12,548       12,548       12,548       12,548       12,548       12,548       0       1,768,85         15.00       DIGOO MEDICAL RECORDS & LI BRARY       2,560       2,560       2,560       6,63,024       0       2,060,13         17.00       DTOO SOCIAL SERVICE       294       2,940       1,398,713       0       1,905,67         30.00       NUMATI ENT ROUTINE SERVICE COST CENTERS       103,016       15,266,119       0       2,40,24,15         31.00       DIOO INTENSI VE CARE UNIT       7,534       7,534       1,514,881       0       2,212,93         31.00       O4300 NURSTERY       2,389       2,389       5,63,813       0       885,52         ANCILLARY SERVICE COST CENTERS       50.00       0       0       0       0       0       0         52.00       DEJONO RECOVERY ROOM       65,516       65,516       8,139,299       0       17,76,65       5         53.00       DSOOO OPERATING ROOM       0       0       0       0       0       0       16,22,32       16,340       11,22,00,96       12,200,96       12,200,96       12,200,96       12,200,96       12,200,96	0, 074 11. 00	1, 940, 074		1, 099, 440	0	0		
15.00       01500       PHARMACY       7,432       7,432       2,867,492       0       3,992,53         16.00       01700       SOCIAL_SERVICE       294       294       1,398,713       0       1,905,67         17.00       000       SOCIAL_SERVICE       294       10,390,713       0       1,905,67         30.00       03100       INTENSIVE CARE UNIT       17,489       19,489       4,497,353       0       7,104,77         10.00       03100       INTENSIVE CARE UNIT       7,534       1,514,881       0       2,212,93         11.00       04100       SUBPROVIDER - IRF       13,258       13,258       13,554,447       0       1,826,91         30.00       04300       NURSERY       2,389       563,813       0       885,52         ANCILLARY SERVICE COST CENTERS         ANCILLARY SERVICE COST CENTERS         ANCILLARY SERVICE COST CENTERS         SUBOD OPELIVERY NEOM       16,516       65,516       8,139,299       0       17,166,59         51.00       05000       PEDIATRICE COST       2,424       47,240       7,383,250       0       11,724,00         52.00       S200       D5200       PEDIATRICE COST <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
16.00       01600       MEDICAL       RECORDS & LIBRARY       2,560       2,560       663,024       0       2,060,137         10.00       1000       SOCIAL       SERVICE       294       294       1,398,713       0       2,060,137         00       03000       AUDITS & PEDIATRIC COST       CENTERS								
INPATI ENT ROUTINE SERVICE COST CENTERS         1         1           30 00         00000 ADULTS & PEDI ATRICS         103,016         103,016         15,266,119         0         24,024,15           31 00         03100         INTENSIVE CARE UNIT         19,489         19,489         4,697,353         0         7,104,77           31 00         03100         SUBPROVIDER - IRF         T         7,534         7,534         1,514,881         0         2,212,93           43.00         04300         SUBPROVIDER - IRF         T         2,389         2,389         563,813         0         885,52           43.00         005000         PERATING ROOM         65,516         65,516         8,139,299         0         17,166,59           50.00         05000         RECORENT ROM         0         0         0         0         120,88           51.00         051000         RADICLOGY - DLAGNOSTIC         47,240         47,240         7,334,250         0         11,724,00           53.00         05300         RELIVERSOUND         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		2, 060, 136						
30.00       COSONO ADULTS & PEDIATRICS       103,016       15,266,119       0       24,024,15         31.00       COSION INTENSIVE CARE UNIT       19,489       19,489       4,697,353       0       7,104,77         31.00       COSION INTENSIVE CARE UNIT       7,534       7,534       1,514,881       0       2,212,93         31.00       COSION UNESRY       2,389       2,389       2,389       2,389       2,389       2,389       0       65,516       8,139,299       0       17,166,75         0.00       COSOO OPERATING ROOM       65,516       65,516       8,139,299       0       17,166,79       9       122,88       122,83       122,83       122,83       122,83       122,83       122,83       122,83       122,83       122,93       123,240       0       17,166,79       12,24,00       12,24,00       12,32       123,253       10       13,11,131       0       0       120,88       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,02       124,02       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00       124,00	<u>)5, 673</u> 17. 00	1, 905, 673	0	1, 398, 713	294	294		
31 00       03100       INTENSIVE CARE UNIT       19, 489       4, 697, 353       0       7, 104, 77         31 00       04100       SUBPROVI DER - IRF       13, 258       13, 258       1, 514, 881       0       2, 212, 93         AX010       O4300       NURSERY       2, 339       2, 389       563, 813       0       885, 52         AX010       ILARY SERVICE COST CENTERS       563, 813       0       885, 52         AX010       RCEORTATING ROOM       65, 516       8, 139, 299       0       17, 166, 59         510.0       05000       ANCHLARY SERVICE       0       0       0       0       0         52.00       05200       05200       MCILLARY SERVICE       47, 240       47, 240       7, 383, 250       0       11, 724, 00         53.00       05300       ANDINERS       0       0       0       0       12, 290, 96         54.00       05400       RADIOLOGY-DI AGNOSTIC       47, 740       47, 740       7, 383, 250       0       11, 724, 00         56.0       05600       REGOO RADIOLOGY-DI AGNOSTIC       0       0       0       0       0       12, 290, 96       56       56       56       56       56       56       0 </td <td>1 15 ( ) 20 0(</td> <td>24 024 154</td> <td>0</td> <td>15 277 110</td> <td>102_01/</td> <td>102 01/</td> <td></td> <td></td>	1 15 ( ) 20 0(	24 024 154	0	15 277 110	102_01/	102 01/		
31.01       IOSIN RECNATAL INTENSIVE CARE UNIT       7,534       7,534       1,514,881       0       2,212,93         41.00       04100       SUBPROVIDER - IRF       13,258       13,258       1,055,447       0       1,826,91         ANCILLARY SERVICE COST CENTERS       2,389       2,389       563,813       0       885,52         ANCILLARY SERVICE COST CENTERS								
43.00         DIRSERY         2,389         2,389         563,813         0         885,52           50.00         05000         DPERATING ROM         65,516         65,516         8,139,299         0         17,166,59           50.00         05000         DPERATING ROM         0								
ANCILLARY SERVICE COST CENTERS           50.00         05000 (PERATING ROOM         65,516         65,516         8,139,299         0         17,166,59           51.00         05100         RECOVERY ROOM         0         0         0         0           52.00         05200         DELIVERY ROOM & LABOR ROOM         13,040         2,081,640         0         3,162,32           53.00         05300         ARSTHESIOLOGY         1,131         1,131         0         0         120,88           54.00         05400         RADI OLOGY-DI AGNOSTI C         47,240         47,240         7,383,250         0         11,724,00           54.01         05401         ULTRASOUND         0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
50.00         OPERATI NG ROOM         65, 516         65, 516         8, 139, 299         0         17, 166, 59           51.00         05200         DELI VERY ROOM         0	35, 525 43. 00	885, 525	0	563, 813	2, 389	2, 389		
51:00       05100       RECOVERY ROOM       0       0       0       0         52:00       05200       DELIVERY ROOM & LABOR ROOM       13,040       13,040       2,081,640       0       3,162,32         53:00       05300       ANESTHESI OLDGY       1,131       1,131       0       0       120,88         54:00       05400       RADI OLGY-JI AGNOSTI C       47,240       47,240       7,383,250       0       11,724,00         54:01       05400       RADI OLGY-JI AGNOSTI C       47,240       47,240       7,383,250       0       11,724,00         54:01       05400       RADI OLGY-JI AGNOSTI C       47,240       7,383,250       0	6, 591 50. 00	17, 166, 591	0	8, 139, 299	65, 516	65, 516		
53.00       05300       ANESTHESI OLOGY       1,131       1,131       0       0       120,88         54.01       05400       RADI OLOGY-DI AGNOSTI C       47,240       47,240       7,383,250       0       11,724,00         54.01       05401       ULTRASOUND       0 <td< td=""><td>0 51.00</td><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td></td<>	0 51.00				0			
54.00       05400       RADI OLOGY-DI AGNOSTI C       47, 240       7, 383, 250       0       11, 724, 00         54.01       05401       ULTRASOUND       0<				2, 081, 640				
54.01         05401         ULTRASOUND         0			-	7 292 250				
56.00         05600         RADI OI SOTOPE         0         0         0         0           57.00         05700         CT SCAN         0	0 54.00			7, 363, 230	47,240			
58.00       05800       MRI       0       0       0       0         60.00       06000       LABORATORY       17,704       17,704       4,789,746       0       12,290,966         65.00       06500       RESPI RATORY THERAPY       3,186       3,186       1,860,545       0       2,783,09         66.00       06000       PHYSI CAL THERAPY       13,745       1,944,020       0       2,979,19         67.00       06700       0CCUPATI ONAL THERAPY       0       0       739,313       941,11         68.00       SPECH PATHOLOGY       0       0       590,812       75,84         69.00       06900       ELECTROCARDI OLOGY       30,112       30,112       4,055,641       0       2,620,166         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       2,630,63         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       18,717,62         74.00       07400       RENAL DI ALYSIS       658       658       0       0       734,86         76.01       03551 WOUND CARE       6,858       847,182       0       1,892,083       0         03951 WOUND CARE	0 56.00		-	0	Ő	0		
60.00       LABORATORY       17, 704       17, 704       17, 704       4, 789, 746       0       12, 290, 966         65.00       06500       RESPI RATORY THERAPY       3, 186       3, 186       1, 860, 545       0       2, 783, 09         66.00       06000       PHYSI CAL THERAPY       13, 745       13, 745       1, 944, 020       0       2, 979, 190         67.00       06700       0CCUPATI ONAL THERAPY       0       0       739, 313       0       941, 11         68.00       06800       SPECH PATHOLOGY       0       0       0       590, 812       753, 44         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       2, 863, 63         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       18, 717, 62         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       0       18, 717, 62         73.00       07300       RUGS CHARGED TO PATI ENTS       0       0       0       0       734, 86         76.01       03451       SLEEP LAB       0       0       0       0       0       0       0       0       0       0 <td>0 57.00</td> <td>-</td> <td>-</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>	0 57.00	-	-	0	0	0		
65.00       06500       RESPI RATORY THERAPY       3, 186       3, 186       1, 860, 545       0       2, 783, 09         66.00       06600       PHYSI CAL THERAPY       13, 745       13, 745       1, 944, 020       0       2, 979, 19         67.00       06700       OCUPATI ONAL THERAPY       0       0       739, 313       0       941, 11         68.00       SPEECH PATHOLOGY       0       0       590, 812       0       753, 44         69.00       06900       ELECTROCARDI OLOGY       30, 112       30, 112       4, 055, 641       0       75, 79, 24         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       2, 620, 160         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       18, 717, 62         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       734, 86         76.00       03950       ANCI LLARY       0       0       0       0       0       0         76.01       03610       SLEEP LAB       0       0       0       0       0       0       0       0       0       0       0       0       0	0 58.00 0,960 60.00	-	-	0 1 700 746	17 704	0		
66.00       06600       PHYSI CAL THERAPY       13,745       13,745       1,944,020       0       2,979,194         67.00       06700       0CCUPATI ONAL THERAPY       0       0       739,313       0       941,11         68.00       06800       SPEECH PATHOLOGY       0       0       590,812       0       753,44         69.00       06900       ELECTROCARDIOLOGY       30,112       30,112       4,055,641       0       7,591,24         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       2,620,16         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       0       28,630,63         74.00       07400       RENAL DI ALYSI S       658       658       0       734,860         76.01       03450       ANCI LLARY       0       0       0       0       0         76.01       03450       SEEV LAB       0       0       0       0       0       0       0       0         76.01       03610       SLEEV LAB       0       0       0       0       0       0       0       0       0       0       0       0       0<								
68.00       06800       SPEECH PATHOLOGY       0       590,812       0       753,44         69.00       06900       ELECTROCARDIOLOGY       30,112       30,112       30,112       4,055,641       0       7,591,24         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       0       2,620,16         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       2,620,16         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       124,101       0       28,630,63         74.00       07400       RENAL DIALYSIS       658       658       0       0       734,86         76.01       03450       SLEEP LAB       0							0 06600 PHYSI CAL THERAPY	66.00 06
69. 00       06900       ELECTROCARDI OLOGY       30, 112       30, 112       4, 055, 641       0       7, 591, 24         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       2, 620, 164         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       28, 630, 63         73. 00       07400       RENAL DI ALYSI S       658       658       0       734, 866         76. 00       03950       ANCI LLARY       0       0       0       0       0         76. 01       03610       SLEEP LAB       0       0       0       0       0       0         76. 03       03951       WOUND CARE       6,858       6,858       847, 182       0       1,892, 08         00. 09000       CLI NI C       0       0       0       0       0       0         90. 00       09000       BERVATI ON BEDS (NON-DI STINCT PART       45, 714       45, 714       6, 227, 434       0       10, 936, 10         92. 00       OSERVATI ON BEDS (NON-DI STINCT PART       SPECI AL PURPOSE COST CENTERS       10, 936, 10       10, 936, 10       10, 936, 10         91. 00       OVOO       GIFT, FLOWER,					0	0		
71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       2, 620, 160         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       18, 717, 62         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       0       124, 101       0       28, 630, 637         74. 00       07400       RENAL DI ALYSI S       658       658       0       0       734, 861         76. 00       03950       ANCI LLARY       0       0       0       0       0       0       0         76. 01       03610       SLEEP LAB       0					30 112	30 112		
73.00       07300       DRUGS CHARGED TO PATIENTS       0       124,101       0       28,630,637         74.00       07400       RENAL DI ALYSI S       658       658       0       0       734,860         76.00       03950       ANCI LLARY       0       0       0       0       0       0       734,860         76.01       03610       SLEEP LAB       0 </td <td>20, 168 71. 00</td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>	20, 168 71. 00		-					
74.00       07400       RENAL DI ALYSI S       658       658       0       0       734,864         76.00       03950       ANCI LLARY       0       0       0       0       0         76.01       03610       SLEEP LAB       0       0       0       0       0       0         76.03       03951       WOUND CARE       6,858       6,858       847,182       0       1,892,08         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0         90.00       09000       CLI NI C       0       0       0       0       0         91.00       09100       EMERGENCY       45,714       45,714       6,227,434       0       10,936,10         92.00       0SERVATI ON BEDS (NON-DI STI NCT PART       45,714       45,714       6,227,434       0       10,936,10         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       45,714       45,714       6,227,434       0       10,936,10         91.00       9100       SUBTOTALS (SUM OF LINES 1 through 117)       660,887       660,887       87,162,012       -62,906,017       199,155,84         NONREL IMBURSABLE COST CENTERS       1       1	7,623 72.00	18, 717, 623	0		0	0	0 07200 IMPL. DEV. CHARGED TO PATIENTS	72.00 072
76. 00       03950       ANCI LLARY       0       0       0       0         76. 01       03610       SLEEP LAB       0       0       0       0       0         76. 01       03610       SLEEP LAB       0       0       0       0       0       0         76. 03       03951       WOUND CARE       6,858       6,858       847,182       0       1,892,089         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0         90. 00       09000       CLI NI C       0       0       0       0       0         91. 00       09100       EMERGENCY       45,714       45,714       6,227,434       0       10,936,104         92. 00       09200       DBSERVATI ON BEDS (NON-DI STINCT PART       5 <td>30, 639 73. 00</td> <td></td> <td>-</td> <td>124, 101</td> <td>0</td> <td>0</td> <td></td> <td></td>	30, 639 73. 00		-	124, 101	0	0		
76. 01       03610       SLEEP LAB       0       0       0       0         76. 03       03951       WOUND CARE       6,858       6,858       847,182       0       1,892,089         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       0         90. 00       09000       CLI NI C       0       0       0       0       0       0       0         91. 00       09100       EMERGENCY       45,714       45,714       6,227,434       0       10,936,100         92. 00       09200       DBSERVATI ON BEDS (NON-DI STINCT PART       5PECI AL PURPOSE COST CENTERS       10,936,100         91. 00       SPECI AL PURPOSE COST CENTERS       5PECI AL PURPOSE COST CENTERS       5         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       660,887       660,887       87,162,012       -62,906,017       199,155,84         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       963       963       66,054       0       111,92*	34, 860 74. 00 0 76. 00		-	0	658	058		
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         0         0         0         0           91.00         091000         EMERGENCY         45,714         45,714         6,227,434         0         10,936,100           92.00         092000         OBSERVATI ON BEDS (NON-DI STINCT PART         45,714         45,714         6,227,434         0         10,936,100           92.00         09SERVATI ON BEDS (NON-DI STINCT PART         SPECIAL PURPOSE COST CENTERS         118.00         SUBTOTALS (SUM OF LINES 1 through 117)         660,887         660,887         87,162,012         -62,906,017         199,155,84           100.00         INOREI MBURSABLE COST CENTERS         1190.00         10000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         963         963         66,054         0         111,92*	0 76.01	-	-	0	Ő	0		
90. 00         09000         CLINIC         0         0         0         0         0           91. 00         09100         EMERGENCY         45, 714         45, 714         6, 227, 434         0         10, 936, 10.           92. 00         0952RVATI ON BEDS (NON-DI STINCT PART         SPECIAL PURPOSE COST CENTERS         10, 936, 10.         10, 936, 10.           118. 00         SUBTOTALS (SUM OF LINES 1 through 117)         660, 887         660, 887         87, 162, 012         -62, 906, 017         199, 155, 84.           190. 00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         963         963         66, 054         0         111, 92.	2, 089 76. 03	1, 892, 089	0	847, 182	6, 858	6, 858		
91. 00 92. 00         09100 09200         EMERGENCY OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS         45, 714         45, 714         6, 227, 434         0         10, 936, 10.           118. 00 NONREI MBURSABLE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         660, 887         660, 887         87, 162, 012         -62, 906, 017         199, 155, 84.           190. 00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         963         963         66, 054         0         111, 92.	0 90.00		0	0	0	0		
92. 00         09200         OBSERVATI ON         BEDS         (NON-DI STINCT PART         Image: Constraint of the state of the sta				6, 227, 434	45, 714	45, 714		
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         660, 887         660, 887         87, 162, 012         -62, 906, 017         199, 155, 84.           NONREI MBURSABLE COST CENTERS         -62, 906, 017         199, 155, 84.         -62, 906, 017         199, 155, 84.           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         963         963         66, 054         0         111, 92.	92.00						0 09200 OBSERVATION BEDS (NON-DISTINCT PART	92.00 092
NONREI MBURSABLE         COST         CENTERS           190. 00         O         FLOWER, COFFEE         SHOP & CANTEEN         963         963         66, 054         0         111, 92'	E 042 110 00	100 155 047	(2.00/.017	07 1/2 012	((0.007	((0.007		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 963 963 66, 054 0 111, 92	5, 842 118.00	199, 155, 842	-02, 900, 017	87, 162, 012	000, 887	000, 887		
192 00 19200 PHYSICIANS' PRIVATE OFFICES 116 678 116 678 0 2 644 42	1, 929 190. 00	111, 929	0	66, 054	963	963		
	4, 435 192. 00		-	0	116, 678	116, 678	00 19200 PHYSI CLANS' PRI VATE OFFI CES	
	0 192.01 0 194.00		0	0	0	0		
	0 194.00		0	0	0	0		
194. 02 07952 SENI OR CI RCLE 0 0 0 0	0 194. 02	0	o o	0	o o	0	02 07952 SENI OR CI RCLE	194.02 07
	53, 568 194. 03		0	0	0	15, 089		
194.04 07954         VACANT UNFINISHED AREA         0         0         0         0         0           200.00         Cross Foot Adjustments         0	0 194. 04 200. 00		0	0	0	0		
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	200.00							
	6, 017 202. 00	62, 906, 017		17, 392, 078	9, 719, 109	8, 077, 001		
Part I)	11215 000 01	0.04404		0.40000/	10 40005	10 177155		202.00
	311315 203. 00 58, 724 204. 00				12. 483956	10. 177455		
Part II)	5, 124 204.00	1,50,724		00, 400				207.00
205.00         Unit cost multiplier (Wkst. B, Part         0.000693         0.00375	03755 205. 00	0. 003755		0. 000693			00 Unit cost multiplier (Wkst. B, Part	205.00
	I	l			I	l	1)	

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Period: From 01/01/2019	Worksheet B-1		
					Date/Time Pre 8/18/2020 12:	pared: 24 pm
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	PORTER MEMORI				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2019	Worksheet B-1	
			T	o 12/31/2019	Date/Time Pre 8/18/2020 12:	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS		I	1			1 1 00
1.00         00100         CAP         REL         COSTS-BLDG         & FIXT           2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE         & GENERAL						1.00 2.00 4.00 5.00
7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG	577, 236 956 6, 177	1, 555, 761 0	570, 103			7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	19, 500 0 3, 449	0	0 3, 449	0 0	100, 210 4, 229	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	13, 548 7, 432 2, 560 294	11, 183	7, 432 2, 560	0 0	2, 408 2, 911 1, 614 1, 809	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	294		294		1, 009	17.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 31. 01 03101 NEONATAL I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	103, 016 19, 489 7, 534 13, 258	99, 860 12, 715	19, 489 7, 534	12, 557 1, 417	18, 590 6, 416 1, 934 1, 507	31.00 31.01
43. 00 04300 NURSERY	2, 389				834	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	65, 516	154, 295	65, 516	142	12, 168	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	-	-	0	51.00
53. 00 05300 ANESTHESI OLOGY	13, 040 1, 131	42, 207 0			3, 080 0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	47,240 0	169, 343 0			10, 343 0	54.00 54.01
56. 00 05600 RADI 0I SOTOPE	0	0		-	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0	-	-	0	
60. 00 06000 LABORATORY	17, 704	264	-	-	9, 348	
65. 00 06500 RESPIRATORY THERAPY	3, 186		-,		2,809	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	13, 745 0	11, 763 0			2, 666 975	
	0	0		-	684	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	30, 112 0				5, 553 0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		-	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0 658		0 658	-	99 0	
76. 00 03950 ANCI LLARY	0	0	0	0	0	•
76. 01 03610 SLEEP LAB 76. 03 03951 WOUND CARE	0 6, 858	-	-	-	0 1. 178	76.01
OUTPATIENT SERVICE COST CENTERS			1			1
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0 45, 714	-	-	-	0 8, 791	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	1					92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	444, 506	1, 555, 761	437, 373	175, 363	99, 946	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	o	264	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	116, 678					190.00
192. 01 19201 OTHER NONREI MBURSABLE 194. 00 07950 NONREI MBURSABLE	0	0	0	0		192.01 194.00
194. 01 07951 MARKETI NG	0	0	-	-		194.00
194. 02 07952 SENI OR CI RCLE	0	0	0			194.02
194. 03 07953 OTHER NONREIMB COST C - REGENCY LTA 194. 04 07954 VACANT UNFINISHED AREA	15, 089 0	0	15, 089 0	21, 966 0		194. 03 194. 04
200.00 Cross Foot Adjustments						200.00 201.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 202.00 Usit cost multiplier (Wkst. B, Dant L)	22, 149, 738				2, 544, 048	202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part	38. 372066 4, 156, 515 7. 200720	34, 150	199, 617	596, 445		204.00
205.00Unit cost multiplier (Wkst. B, Part11)206.00NAHE adjustment amount to be allocated	7. 200720	0. 021951	0. 350142	2. 460044	0. 080301	205.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						207.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	PORTER MEMORIA	AL HOSPITAL Provider CO		Period:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2019 To 12/31/2019	Date/Time Pre 8/18/2020 12:	pared
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	
		(NURSING WA GES)	(COSTED REQUIS.)	15.00	(GROSS CHARGES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMI NI STRATI VE & GENERAL						5.0
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.0
9.00 9.00	00900 HOUSEKEEPING						9.0
10.00	01000 DI ETARY						10.0
11.00	01100 CAFETERI A						11.0
13.00	01300 NURSING ADMINISTRATION	34, 236, 295	0/ 405 004				13.0
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	36, 425, 201 0	20 550 071			14.0
16.00	01600 MEDICAL RECORDS & LIBRARY	0	7, 985	28, 558, 071 (			16.0
17.00	01700 SOCIAL SERVICE	1,010,850	2, 506			62, 242	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	12, 054, 090	1, 842, 089			47, 700	
31.00	03100 I NTENSI VE CARE UNI T	3, 970, 223	658, 801			5, 925	
31.01 41.00	03101 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	1, 465, 500 840, 564	108, 480 63, 529			2, 827 3, 152	
43.00	04300 NURSERY	040, 504	57, 966			2, 638	
	ANCI LLARY SERVICE COST CENTERS		011700			2,000	
50.00	05000 OPERATING ROOM	5, 034, 512	4,003,459			0	50.0
51.00	05100 RECOVERY ROOM	0	0	(		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 258, 865	237, 016				
3.00 4.00	05400 RADI OLOGY - DI AGNOSTI C	806, 059	71, 254 1, 100, 420			0	53.0 54.0
54.01	05401 ULTRASOUND	000,007	1, 100, 420			0	54.0
56.00	05600 RADI OI SOTOPE	0	0	0	0 0	0	56.0
57.00	05700 CT SCAN	0	0	0		0	57.0
58.00		0	0	(		0	
50.00 55.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	3, 959, 209 303, 744			0	
56. 00	06600 PHYSI CAL THERAPY	0	19, 895			0	
57.00	06700 OCCUPATI ONAL THERAPY	0	40	(		0	
58.00	06800 SPEECH PATHOLOGY	0	0	0	-,,	0	68.0
59.00	06900 ELECTROCARDI OLOGY	1, 903, 124	1, 644, 991	(		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 105, 216 19, 232, 576			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	
4.00	07400 RENAL DI ALYSI S	0	0	(	4, 324, 287	0	
76.00	03950 ANCI LLARY	0	0	0		0	
6.01	03610 SLEEP LAB	0	0	(		0	
6. 03	03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS	767, 122	145, 609	<u> </u>	0 11, 740, 219	0	76.
90.00		0	0	(	0 0	0	90. (
91.00	09100 EMERGENCY	5, 125, 386	860, 416	0	0 196, 543, 266	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	34, 236, 295	36, 425, 201	28 558 071	2, 163, 480, 324	62, 242	118 (
10.00	NONREI MBURSABLE COST CENTERS	54,250,275	30, 423, 201	20, 330, 07	2, 103, 400, 324	02, 242	1110.0
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190. (
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0 0		192.
	19201 OTHER NONREI MBURSABLE	0	0	(	0		192.
	07950 NONREI MBURSABLE 07951 MARKETI NG	0	0				194. 194.
	207952 SENIOR CIRCLE	0	0				194. 194.
	07953 OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0 0		194.
	07954 VACANT UNFINISHED AREA	0	0	(	0 0	0	194.
00.00							200.
01.00 02.00	Cost to be allocated (per Wkst. B,	6, 141, 839	3, 029, 612	5, 675, 867	2, 864, 515	2, 740, 353	201. 202.
03.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 179396	0. 083174	0. 198748	0. 001324	44.027393	203.
04.00		123, 650	416, 837				1
205.00	Unit cost multiplier (Wkst. B, Part	0. 003612	0. 011444	0.008474	0. 000040	0. 334694	205.
206. 00							206.
	(per Wkst. B-2)			1			1

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-0035		Worksheet B-1	
			_	From 01/01/2019 To 12/31/2019		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(NURSING WA	(COSTED		(GROSS		
	GES)	REQUIS.)		CHARGES)		
	13.00	14.00	15.00	16.00	17.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/18/2020 12:	pared: 24 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	44, 218, 880		44, 218, 88	0 0	44, 218, 880	30.00
31. 00 03100 INTENSIVE CARE UNIT	11, 771, 220		11, 771, 22		11, 771, 220	
31. 01  03101 NEONATAL INTENSIVE CARE UNIT	3, 761, 659		3, 761, 65		3, 761, 659	
41. 00  04100  SUBPROVI DER - I RF	3, 537, 358		3, 537, 35		3, 537, 358	
43. 00 04300 NURSERY	1, 422, 532		1, 422, 53		1, 422, 532	
ANCI LLARY SERVICE COST CENTERS	1,422,332		1,422,50	02 0	1, 422, 332	43.00
50. 00 05000 OPERATING ROOM	27, 867, 142		27, 867, 14	2 0	27, 867, 142	50.00
51. 00 05100 RECOVERY ROOM	27,007,142		27,007,12	0 0	27,007,142	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 194, 876		5, 194, 87	0 0 76 0	5, 194, 876	
53. 00 05300 ANESTHESI OLOGY	245, 320		245, 32		245, 320	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 677, 676		18, 677, 67		18, 677, 676	
54. 01  05401  ULTRASOUND	10, 077, 070		10,077,07		0	
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	
57. 00 05700 CT SCAN	0			0 0	0	1
58. 00 05800 MRI	0			0 0	0	1
60, 00 06000 LABORATORY	17, 837, 779		17, 837, 77	9 0	17, 837, 779	
65. 00 06500 RESPI RATORY THERAPY	3, 971, 967	0	3, 971, 96		3, 971, 967	
66. 00 06600 PHYSI CAL THERAPY	4, 672, 957	0	4, 672, 95		4, 672, 957	•
67.00 06700 OCCUPATI ONAL THERAPY	1, 275, 188	0	1, 275, 18		1, 275, 188	
68. 00 06800 SPEECH PATHOLOGY	1,012,001	0	1, 012, 00		1, 012, 001	
69. 00 06900 ELECTROCARDI OLOGY	12, 379, 077	J. J	12, 379, 07		12, 379, 077	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 666, 731		3, 666, 73		3, 666, 731	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	26, 402, 057		26, 402, 05		26, 402, 057	
73.00 07300 DRUGS CHARGED TO PATIENTS	43, 607, 227		43, 607, 22		43, 607, 227	
74. 00 07400 RENAL DI ALYSI S	1,000,559		1,000,55		1,000,559	
76. 00 03950 ANCI LLARY	0		.,	0 0	0	1
76. 01 03610 SLEEP LAB	0			0 0	0	
76. 03 03951 WOUND CARE	3,044,003		3, 044, 00	03 0	3, 044, 003	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	18, 379, 123		18, 379, 12	3 0	18, 379, 123	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 274, 456		4, 274, 45		4, 274, 456	
200.00 Subtotal (see instructions)	258, 219, 788	0			258, 219, 788	
201.00 Less Observation Beds	4, 274, 456		4, 274, 45		4, 274, 456	
202.00 Total (see instructions)	253, 945, 332	0	253, 945, 33	2 0	253, 945, 332	200 00

Health Financial Systems	PORTER MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/18/2020 12:	pared: 24 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	150, 780, 155		150, 780, 15	. c		30.00
31. 00 03100 INTENSIVE CARE UNIT	32, 911, 826		32, 911, 82			31.00
31. 01  03101 NEONATAL INTENSIVE CARE UNIT	16, 489, 305		16, 489, 30			31.00
41. 00  04100  SUBPROVIDER - IRF	9, 118, 998		9, 118, 99			41.00
43. 00 04300 NURSERY	4, 464, 436		4, 464, 43			41.00
ANCI LLARY SERVICE COST CENTERS	4, 404, 430		4, 404, 43			43.00
50. 00 05000 OPERATI NG ROOM	162, 239, 145	221, 679, 542	383, 918, 68	0. 072586	0.00000	50.00
51. 00 05100 RECOVERY ROOM	102, 207, 140	221,077,342		0 0.000000	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	16, 405, 981	77,047			0.000000	
53. 00 05300 ANESTHESI OLOGY	9, 309, 574	11, 269, 755			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	60, 232, 767	204, 278, 176			0.000000	
54. 01 05401 ULTRASOUND	00,202,707	201, 270, 170		0 0.000000	0.000000	
56. 00 05600 RADI 0I SOTOPE	0	0		0 0.000000	0.000000	
57. 00 05700 CT SCAN	0	0		0 0.000000	0. 000000	1
58. 00 05800 MRI	0	0		0 0.000000	0. 000000	
60. 00 06000 LABORATORY	97, 997, 932	139, 179, 175	237, 177, 10		0. 000000	
65. 00 06500 RESPIRATORY THERAPY	53, 342, 787	3, 159, 508			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	13, 685, 287	9, 260, 988			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	10, 470, 335	1, 868, 043			0. 000000	
68.00 06800 SPEECH PATHOLOGY	2, 496, 328	2, 511, 520			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	64, 969, 170	107, 603, 001			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 129, 149	18, 990, 397			0. 000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	117, 644, 824	77, 010, 384			0. 000000	1
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 311, 844	217, 587, 416			0. 000000	
74.00 07400 RENAL DIALYSIS	4, 266, 726	57, 561			0, 000000	
76. 00 03950 ANCI LLARY	0	0		0 0.000000	0. 000000	
76. 01 03610 SLEEP LAB	0	0		0 0.000000	0. 000000	
76. 03 03951 WOUND CARE	401, 768	11, 338, 451	11, 740, 2 <sup>°</sup>		0. 000000	
OUTPATIENT SERVICE COST CENTERS	1017700	11/000/101	11, 110, 2	01207200	0.000000	10100
90. 00 09000 CLINIC	0	0		0 0.000000	0.00000	90.00
91. 00 09100 EMERGENCY	58, 162, 807	138, 380, 459	196, 543, 26		0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 152, 246	11, 245, 511			0. 000000	
200.00 Subtotal (see instructions)		1, 175, 496, 934				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	007 000 000	1 175 407 004	2, 163, 480, 32			202.00

alth Financial Systems	PORTER MEMORIAL			u of Form CMS-2552-
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0035	Peri od:	Worksheet C
			From 01/01/2019 To 12/31/2019	Part I Date/Time Prepared
			10 12/31/2019	8/18/2020 12:24 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	-		
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
D. 00 03000 ADULTS & PEDIATRICS				30. 0
. 00 03100 I NTENSI VE CARE UNI T				31. (
. 01 03101 NEONATAL INTENSIVE CARE UNIT				31. (
. 00 04100 SUBPROVIDER - IRF				41.0
3. 00 04300 NURSERY				43.0
ANCI LLARY SERVI CE COST CENTERS				
0. 00 05000 OPERATING ROOM	0. 072586			50. (
00 05100 RECOVERY ROOM	0. 000000			51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 315165			52.0
3. 00 05300 ANESTHESI OLOGY	0. 011921			53.0
. 00 05400 RADI OLOGY-DI AGNOSTI C	0.070612			54.0
. 01 05401 ULTRASOUND	0. 000000			54.0
00 05600 RADI OI SOTOPE	0. 000000			56.0
7. 00 05700 CT SCAN	0, 000000			57.0
3. 00 05800 MRI	0. 000000			58.0
D. 00 06000 LABORATORY	0. 075209			60.0
5. 00 06500 RESPIRATORY THERAPY	0.070297			65.0
5. 00 06600 PHYSI CAL THERAPY	0. 203648			66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0. 103351			67.0
3. 00 06800 SPEECH PATHOLOGY	0. 202083			68.0
2. 00 06900 ELECTROCARDI OLOGY	0. 071733			69.0
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 087055			71.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 135635			71.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 149905			72.0
4. 00 07400 RENAL DIALYSIS	0. 231381			73.0
5. 00 03950 ANCI LLARY	0. 000000			74.0
5. 01 03930 ANCT LLART 5. 01 03610 SLEEP LAB	0. 000000			76.0
5. 03 03951 WOUND CARE	0. 259280			76.0
OUTPATIENT SERVICE COST CENTERS	0. 239200			/0.0
0. 00 09000 CLINIC	0.000000			90.0
. 00 09100 EMERGENCY	0. 000000			90.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245690			92. (
00.00 Subtotal (see instructions)				200. (
D1.00 Less Observation Beds				201. (
02.00 Total (see instructions)				202. (

Heal th	Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/18/2020 12:	epared: 24 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	44, 218, 880		44, 218, 88		44, 218, 880	
31.00		11, 771, 220		11, 771, 22		11, 771, 220	
31.01	03101 NEONATAL INTENSIVE CARE UNIT	3, 761, 659		3, 761, 65		3, 761, 659	
41.00	04100 SUBPROVIDER - IRF	3, 537, 358		3, 537, 35		3, 537, 358	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 422, 532		1, 422, 53	0	1, 422, 532	43.00
	OSOOO OPERATING ROOM	27.047.142		27.0(7.1)	2 0		1 50 00
50.00 51.00	05100 RECOVERY ROOM	27, 867, 142		27, 867, 14	0 0	27, 867, 142	
51.00	05200 DELIVERY ROOM & LABOR ROOM	5, 194, 876		E 104 0	0	0 E 104 974	
52.00	05300 ANESTHESI OLOGY	245, 320		5, 194, 87 245, 32		5, 194, 876 245, 320	•
53.00	05400 RADI OLOGY-DI AGNOSTI C	18, 677, 676		18, 677, 67		18, 677, 676	
54.00	05401 ULTRASOUND	10, 077, 070		10, 077, 0		18, 077, 070	
56.00	05600 RADI OI SOTOPE	0			0 0	0	
57.00	05700 CT SCAN	0				0	
58.00	05800 MRI	0				0	
60.00	06000 LABORATORY	17, 837, 779		17, 837, 77	0 0	17, 837, 779	
65.00	06500 RESPI RATORY THERAPY	3, 971, 967	0	3, 971, 96		3, 971, 967	
66.00	06600 PHYSI CAL THERAPY	4, 672, 957	0	4, 672, 95		4, 672, 957	
67.00	06700 OCCUPATI ONAL THERAPY	1, 275, 188	0	1, 275, 18		1, 275, 188	
68.00	06800 SPEECH PATHOLOGY	1, 012, 001	0	1, 012, 00		1, 012, 001	
69.00	06900 ELECTROCARDI OLOGY	12, 379, 077		12, 379, 07		12, 379, 077	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 666, 731		3, 666, 73		3, 666, 731	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	26, 402, 057		26, 402, 05		26, 402, 057	
73.00	07300 DRUGS CHARGED TO PATIENTS	43, 607, 227		43, 607, 22		43, 607, 227	
74.00		1,000,559		1,000,55		1,000,559	
76.00	03950 ANCI LLARY	0		.,,	0 0	0	
76.01	03610 SLEEP LAB	0			0 0	0	•
76.03		3,044,003		3, 044, 00	03 0	3, 044, 003	76.03
	OUTPATIENT SERVICE COST CENTERS						
90.00		0			0 0	0	90.00
91.00	09100 EMERGENCY	18, 379, 123		18, 379, 12	3 0	18, 379, 123	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 274, 456		4, 274, 45		4, 274, 456	
200.00		258, 219, 788		258, 219, 78	0 8	258, 219, 788	200.00
201.00	Less Observation Beds	4, 274, 456		4, 274, 45	6	4, 274, 456	201.00
202.00	) Total (see instructions)	253, 945, 332		253, 945, 33	0	253, 945, 332	

Health Financial Systems	PORTER MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/18/2020 12:	pared: 24 pm
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	150, 780, 155		150, 780, 15			30.00
31.00 03100 I NTENSI VE CARE UNI T	32, 911, 826		32, 911, 82			31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	16, 489, 305		16, 489, 30			31.01
41.00 04100 SUBPROVIDER - IRF	9, 118, 998		9, 118, 99			41.00
43. 00 04300 NURSERY	4, 464, 436		4, 464, 43	36		43.00
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATING ROOM	162, 239, 145	221, 679, 542			0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	16, 405, 981	77, 047			0.00000	
53.00 05300 ANESTHESI OLOGY	9, 309, 574	11, 269, 755			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	60, 232, 767	204, 278, 176			0.00000	
54.01 05401 ULTRASOUND	0	0		0 0.000000	0. 000000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0. 000000	1
57.00 05700 CT SCAN	0	0		0 0.000000	0.00000	
58. 00 05800 MRI	0	0		0 0.000000	0. 000000	
60. 00 06000 LABORATORY	97, 997, 932	139, 179, 175			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	53, 342, 787	3, 159, 508			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	13, 685, 287	9, 260, 988			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	10, 470, 335	1, 868, 043			0. 000000	
68.00 06800 SPEECH PATHOLOGY	2, 496, 328	2, 511, 520			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	64, 969, 170	107, 603, 001			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 129, 149	18, 990, 397	42, 119, 54	0. 087055	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	117, 644, 824	77,010,384			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 311, 844	217, 587, 416	290, 899, 26		0. 000000	73.00
74. 00 07400 RENAL DIALYSIS	4, 266, 726	57, 561	4, 324, 28		0.00000	
76. 00 03950 ANCI LLARY	0	0		0 0.000000	0.00000	76.00
76. 01 03610 SLEEP LAB	0	0		0 0.000000	0.00000	76.01
76.03 03951 WOUND CARE	401, 768	11, 338, 451	11, 740, 21	0. 259280	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	0	0		0 0.000000	0. 000000	90.00
91.00 09100 EMERGENCY	58, 162, 807	138, 380, 459	196, 543, 26	0. 093512	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 152, 246	11, 245, 511	17, 397, 75	0. 245690	0. 000000	92.00
200.00 Subtotal (see instructions)	987, 983, 390	1, 175, 496, 934	2, 163, 480, 32	24		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	987, 983, 390	1, 175, 496, 934	2, 163, 480, 32	24		202.00

ealth Financial Systems DMPUTATION OF RATIO OF COSTS TO CHARGES	PORTER MEMORIAL	Provider CCN: 15-0035		u of Form CMS-2552 Worksheet C
JMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0035	Period: From 01/01/2019	Part I
			To 12/31/2019	Date/Time Prepare
				8/18/2020 12:24 p
Cast Castan Darasi ati an	DDC Langett and	Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
D. 00 03000 ADULTS & PEDIATRICS				30.
I. 00 03100 I NTENSI VE CARE UNI T				31.
. 01 03101 NEONATAL INTENSIVE CARE UNIT				31.
. 00 04100 SUBPROVIDER - IRF				41.
3. 00 04300 NURSERY				43.
ANCILLARY SERVICE COST CENTERS				
0. 00 05000 OPERATING ROOM	0. 000000			50.
. 00 05100 RECOVERY ROOM	0. 000000			51.
. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
. 00 05300 ANESTHESI OLOGY	0. 000000			53.
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
. 01 05401 ULTRASOUND	0. 000000			54.
. 00 05600 RADI OI SOTOPE	0. 000000			56.
. 00 05700 CT SCAN	0. 000000			57.
. 00 05800 MRI	0. 000000			58.
. 00 06000 LABORATORY	0. 000000			60.
00 06500 RESPI RATORY THERAPY	0. 000000			65.
0. 00 06600 PHYSI CAL THERAPY	0. 000000			66.
00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
8. 00 06800 SPEECH PATHOLOGY	0. 000000			68.
. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.
. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
. 00 07400 RENAL DIALYSIS	0. 000000			74.
0. 00 03950 ANCI LLARY	0. 000000			76.
0. 01 03610 SLEEP LAB	0. 000000			76.
5. 03 03951 WOUND CARE	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS				
0. 00 09000 CLINIC	0. 000000			90.
. 00 09100 EMERGENCY	0. 000000			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.
0.00 Subtotal (see instructions)				200.
01.00 Less Observation Beds				201.
D2.00 Total (see instructions)				202.

Health Financial Systems	PORTER MEMORI	AL_HOSPITAL		In Li€	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 24 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 665, 564	0	3, 665, 56	4 52, 159	70.28	30.00
31.00 INTENSIVE CARE UNIT	677, 516		677, 51	6 5, 925	114.35	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	249, 039		249, 03	9 2, 827	88.09	31.01
41.00 SUBPROVIDER - IRF	439, 039	0	439, 03	9 3, 152	139.29	41.00
43.00 NURSERY	77, 685		77, 68	5 2, 638	29.45	43.00
200.00 Total (lines 30 through 199)	5, 108, 843		5, 108, 84	3 66, 701		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	19, 806	1, 391, 966				30.00
31.00 INTENSIVE CARE UNIT	2, 865	327, 613				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
41.00 SUBPROVIDER - IRF	2,146	298, 916				41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	24, 817	2, 018, 495				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS         Provider CON: 15-0035         Period: Part II Title XVIII         Period: Part II Date Time Prepared: B/18/2020         Worksheet D Part II Date Time Prepared: B/18/2020           Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Total Charges (col. 1 + col. 26)         Ratio of Cost to Charges (col. 1 + col. 2)         Inpatient Cost Center Description         Object Cost Column 3 x Column 4)           MACILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00 00 SC000 (PEEDNERY ROOM 52.00 00 SC000 (PEEDNERY ROOM 52.00 00 SC000 (PEEDNERY ROOM 54.00 05400 (PADILOGY-DI AGNOSTIC 54.00 05400 (PADILOGY-DI AGNOSTIC 54.00 05400 (PADILOGY-DI AGNOSTIC 55.00 05500 (Column 4)         1.507,286         264,510,943         0.000000 0         0         58.00 0         0.0000000 0         0         54.00 0         54.00 0         54.00 0         55.00 0         56.00 0         56.00 0         56.00 0         56.00 0         56.00 0         56.00 0         56.00 0         56.00 0         57.00 0         56.00 0         57.00 0         56.00 0         57.00 0         57.00 0         57.00 0         57.00 0         57.00 0         56.00 0	Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description         Capital Related Cost (from Wkst. C, Part I, col. 26)         Total charges (col. 1 + col. 2)         Inpatient to Charges (col. 1 + col. 2)         Capital Costs (col.um 3 x column 4)           ANCILLARY SERVICE COST CENTERS         20         3.00         4.00         5.00           50.00         05000 (PEATI NG R00M 52200 (PELIVERY ROOM 0 (PECOVERY ROOM 52.00 (PECOVERY ROOM 52.00 (PECOVERY ROOM 53.00 (PECOVERY ROOM 54.00 (PECOVERY ROOM 54.00 (PECOVERY ROOM 54.00 (PECOVERY ROOM 54.00 (PACOVER)         2,132,779 36,222         383,918,687 0 (PECOVERY ROOM 52.00 (PECOVERY ROOM 52.00 (PECOVERY ROOM 52.00 (PACOVER)         0         0.000555 02,294,971         346,049 0 (PECOVERY ROOM 53.00         50.00           51.00 (DS100 RECOVERY ROOM 54.00 (PS400 RADI OLOGY - DI AGNOSTI C 54.01 (PECOVERY ROOM 54.00 (PS400 RADI OLOGY - DI AGNOSTI C 55.00 (PECOVERY ROOM 65.00 (PACOVER)         1,507.286 0 (PECOVERY AGNOSTI C 0 (PECOVERY AGNOSTI C 1,507.286         0         0         0.000000 0 (PECOVERY AGNOSTI C 0 (PECOVERY AGNOSTI C 1,507.286         0         0         0.000000 0 (PECOVERY AGNOSTI C 1,507.286         0			Provider C		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	pared: 24 pm
Rel ated Cost (from Wist.) 20)         Part I, col. 20)         Program (col lum 3 x col um 4)         (col um 3 x col um 4)           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (DPERATI NG ROM         2.132,779         383,918,687         0.005555         62,294,971         346,049         50.00           51.00         05300 ALSENTRESI OLOGY         362,201         16,483,028         0.025602         0         0         52.00           53.00         05300 ALSENTESI OLOGY         36,262         20,579,329         0.001762         2,891,999         5,096         53.00           54.00         05400 RADI ULTRASOUND         0         0         0.000000         0         0         57.00           57.00         05700 CT SCAN         0         0         0.000000         0         57.00           58.00         05600 RESPI RATORY THERAPY         13,958         56,502,295         0.00217         2,608,635,3649         55.00           50.00         06000 LABDRATORY         4,618         12,338,378         0.00374         4,163,673         11,557         67.00           66.00         06600 SPEECH PATHOLOGY         3,499         5,007,848         0.000574						PPS	
ANCI LLARY SERVICE COST CENTERS         (from Wkst. B, Part II, col. 2)         Part I, col. 2)         (col. 2)	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col.         8)         2)         3         4           26)         1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 [PERATING ROM         2.132,779         383,918,687         0.005555         62,294,971         346,049         50.00           51.00         05200 [DELIVERY ROM & LABOR ROOM         422,001         16,483,028         0.005602         0         52.00           53.00         05300 ANESTHESI OLOGY         36,262         20,579,329         0.01762         2,891,999         5,096         53.00           54.01         05400 RADI ULTRASOUND         0         0         0.000000         0         54.01           55.00         05500 KISTIC         1.507,286         264,510,943         0.005098         26,807,064         152,747         54.01           56.00         05600 RADI ULTRASOUND         0         0         0.000000         0         55.00           57.00 CT SCAN         0         0         0.000000         0         58.00         0.5000 RSD RADY RATORY THERAPY         139,585         56,502,295         0.0021712,56,83,656         56.500 </td <td></td> <td>Related Cost</td> <td>(from Wkst. C,</td> <td>to Charges</td> <td>Program</td> <td>(column 3 x</td> <td></td>		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
26)         1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         50.00         05000         0PERATING ROOM         2, 132, 779         383, 918, 687         0.005555         62, 294, 971         346, 049         50.00           51.00         05100         RCOVERY ROOM         2, 132, 779         0         0         0.0000000         0         0         51.00           52.00         05200         DELI VERY ROOM & LABOR ROOM         422, 001         16, 483, 028         0.025602         0         0         52.00           53.00         05300         ANESTHESI 0LOGY         36, 262         20, 579, 329         0.001762         2, 891, 999         5, 096         53.00           54.00         105401         ULTRASOUND         0         0         0.000000         0         152, 747         54.00           55.00         05600         RADI 0STOPE         0         0         0.000000         0         0         56.00           56.00         05600         NRI         0         0         0.000000         0         57.00         58.00           63.00         06500         RESPI RATORY         439,942         22,946,275         0.018714					. Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         0         0         0.00500         00ERTING ROOM         2.132,779         383,918,687         0.005555         62,294,971         346,049         50.00           51.00         05300         DELIVERY ROOM & LABOR ROOM         422,001         16,483,028         0.025602         0         0         51.00           54.00         05300         ANDI DLOGY DI AGNOSTI C         1,507,286         264,510,943         0.005698         26,807,064         152,747         54.00           54.01         05600         RADI OLOGY DI AGNOSTI C         1,507,286         264,510,943         0.005698         26,807,064         152,747         54.00           54.00         05600         RADI OLOGY DI AGNOSTI C         0         0         0.000000         0         0         56.00           57.00         05700 CT SCAN         0         0         0.000000         0         0         58.00         05800 MRI         0         0.000000         0         0         58.00           60.00         06500         REPSI RATORY THERAPY         113,958         56,502,295         0.002171         56,608,366		Part II, col.	8)	2)			
ANCI LLARY SERVICE COST CENTERS           50.00         05000         0PERATING ROOM         2, 132, 779         383, 918, 687         0.005555         62, 294, 971         346, 049         50.00           51.00         05100 RECOVERY ROOM         0         0         0.000000         0         0         51.00           52.00         05200 DELI VERY ROOM & LABOR ROOM         422, 001         16, 483, 028         0.025602         0         0         52.00           53.00         05400 RADI OLOGY -DI AGNOSTI C         1, 507, 286         26, 510, 943         0.005698         26, 807, 064         152, 747         54.00           54.01         05401         ULTRASOUND         0         0         0         0.000000         0         0         56.00           55.00         05600 RADI 01 SOTOPE         0         0         0         0.000000         0         0         56.00           60.00         06000 ILABORATORY         639, 904         237, 177, 107         0.002698         40, 864, 675         110, 253         66.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00							
50.00       05000       0PERATING ROOM       2, 132, 779       383, 918, 687       0.005555       62, 294, 971       346, 049       50.00         51.00       05100       DELIVERY ROOM & LABOR ROOM       422, 001       16, 483, 028       0.005502       0       0       0       0       0       0       0       0       0       0       51.00       0       52.00       05300 ANESTHESI OLOGY       36, 262       20, 579, 329       0.001762       2, 891, 999       5, 996       53.00       0       54.01       05401       ULTRASOUND       0       0.000000       0       0       54.01       05401       ULTRASOUND       0       0.000000       0       0       56.00       0       0.000000       0       0       56.00       0       0.000000       0       0       56.00       0       0.000000       0       0       56.00       0       0.000000       0       0       58.00       0.000000       0       0       0.000000       0       58.00       0.000000       0       0       0.000000       0       56.00       0.000000       0       56.00       0.000000       0       0.000000       0       56.00       0.000000       0       0.000000       0       0.000		1.00	2.00	3.00	4.00	5.00	
51.00       05100       RECOVERY ROOM       422,01       64,83,028       0.00000       0       0       51.00         52.00       05200       DELI VERY ROOM & LABOR ROOM       422,01       16,483,028       0.025602       0       0       52.00         53.00       05200       RETHESI DLOGY       36,262       20,579,329       0.001762       2.891,999       5.096       53.00         54.01       05401       RUTRASOUND       0       0       0.000000       0       0       54.01         54.01       05401       UTRASOUND       0       0       0.000000       0       0       56.00         54.01       05401       UTRASOUND       0       0       0.000000       0       56.00         55.00       05500       RESPI RATORY       639,904       237,177,10       0.002698       40,864,675       110,253       60.00         66.00       06600       RESPI RATORY THERAPY       429,420       22,946,275       0.018714       5,448,150       101,957       66.00         67.00       05000       REPTI ROMATRAPY       429,420       22,946,275       0.018714       5,448,150       101,957       67.00         68.00       06800       SPEECH PATHO		1		1			
52.00       05200       DELI VERY ROOM & LABOR ROOM       422,001       16,483,028       0.025602       0       0       52.00         53.00       05300       ANESTHESI DLOGY       36,262       20,579,329       0.001762       2,891,999       5,096       53.00         54.00       05400       RADI DLOGY-DI AGNOSTI C       1,507,286       264,510,943       0.005098       26,807,044       152,747       54.00         54.01       05401       ILTRASOUND       0       0       0.000000       0       54.01         55.00       05700       CT SCAN       0       0       0.000000       0       57.00         58.00       06500       RADRATORY       639,904       237,177,107       0.002698       40,864,675       110,253       60.00         56.00       06500       RESPI RATORY THERAPY       429,420       22,946,275       0.00217       26,608,366       53.669       65.00         67.00       06600       PHYSI CAL THERAPY       4,618       12,338,378       0.000374       4,163,673       1,557       67.00         68.00       06800       SPECH PATHOLOGY       34,913       5,007,848       0.000548       98,0111       644       68.00       0.001522       53,55727 <td></td> <td></td> <td></td> <td></td> <td></td> <td>346, 049</td> <td>•</td>						346, 049	•
53.00       05300       ANESTHESI OLOGY       36, 262       20, 579, 329       0.001762       2, 891, 999       5, 096       53.00         54.01       05400       RADI OLOGY-DI AGNOSTI C       1, 507, 286       264, 510, 943       0.005698       26, 807, 064       152, 747       54.00         56.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       0.000000       0       54.01         56.00       05600       RADI OLSOTOPE       0       0       0.000000       0       56.00         57.00       05700       CT SCAN       0       0       0.000000       0       57.00         58.00       0800       RESPI RATORY THERAPY       639, 904       237, 177, 107       0.002698       40, 864, 675       110, 253       60.00         66.00       06500       RESPI RATORY THERAPY       113, 958       56, 502, 295       0.002017       26, 608, 366       53, 669       65.00         66.00       06700       OCUPATI ONAL THERAPY       4, 618       12, 338, 378       0.000374       4, 163, 673       1, 557       67.00         06700       DCUPATI ONAL THERAPY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00       77.07       71.		-	-				
54.00       05400       RADI OLOGY-DI AGNOSTI C       1,507,286       264,510,943       0.005698       26,807,064       152,747       54.01         54.01       05401       JUTRASOUND       0       0       0.000000       0       54.01         56.00       RADI OLOGY-DI AGNOSTI C       0       0       0.000000       0       0       54.01         56.00       RADI OLOGY-DI AGNOSTI C       0       0       0.000000       0       0       54.01         57.00       05700       CT SCAN       0       0       0.000000       0       57.00         58.00       06000       LABORATORY       639,904       237,177,107       0.002698       40,864,675       110,253       60.00         66.00       06000       LABORATORY       639,904       237,177,107       0.002698       40,864,675       110,957       66.00         65.00       06500       REPI RATORY THERAPY       429,420       22,946,275       0.018714       5,448,150       101,957       66.00         67.00       06700       0CCUPATI ONAL THERAPY       4,618       12,338,378       0.000374       4,153,673       1,557       67.00         68.00       0SPEECH PATHOLOGY       3,493       5,007,848 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
54. 01       05401       ULTRASOUND       0       0       0       54. 01         56. 00       05600       RADI 0I SOTOPE       0       0       0.000000       0       56. 00         57. 00       05700       CT SCAN       0       0       0.000000       0       0       58. 00         58. 00       05800       MRI       0       0       0.000000       0       0       58. 00         60. 00       06000       LABORATORY       639, 904       237, 177, 107       0.002698       40, 864, 675       110, 253       60. 00         65. 00       06600       PHYSI CAL THERAPY       429, 420       22, 946, 275       0.018714       5, 448, 150       101, 957       66. 00         66. 00       06600       CUPATI ONAL THERAPY       429, 420       22, 946, 275       0.018714       5, 445, 150       101, 957       66. 00         67. 00       06600       SPECH PATHOLOGY       3, 493       5, 007, 848       0.000374       4, 163, 673       1, 557       67. 00         68. 00       06900       ELCTROCARD IOLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69. 00         71. 00       07100       MEDI CAL SUPPLI				0.00176	52 2, 891, 999	5, 096	53.00
56.00         05600         RADI 0I SOTOPE         0         0         0.000000         0         56.00           57.00         CT SCAN         0         0         0.000000         0         57.00           58.00         05800         MRI         0         0         0.000000         0         58.00           60.00         06000         LABORATORY         639,904         237,177,107         0.002698         40,864,675         110,253         60.00           65.00         06500         RESPI RATORY THERAPY         113,958         56,502,295         0.002017         26,608,366         53,669         65.00           66.00         06600         PHYSI CAL THERAPY         4,618         12,338,378         0.000374         4,163,673         1,557         67.00           67.00         06700         OCCUPATI ONAL THERAPY         4,618         12,338,378         0.000374         4,163,673         1,557         67.00           68.00         06800         SPEECH PATHOLOGY         3,493         5,007,848         0.000548         28,015,106         159,238         69.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         298,158         194,655,208         0.001532         53,595,727 </td <td></td> <td>1, 507, 286</td> <td>264, 510, 943</td> <td></td> <td></td> <td>152, 747</td> <td></td>		1, 507, 286	264, 510, 943			152, 747	
57.00       05700       CT SCAN       0       0       0.000000       0       0       57.00         58.00       05800       MRI       0       0       0.000000       0       0       58.00         60.00       06000       LABORATORY       639, 904       237, 177, 107       0.002698       40, 864, 675       110, 253       60.00         65.00       06000       RESPI RATORY THERAPY       413, 958       56, 502, 295       0.002017       26, 608, 366       53, 669       65.00         66.00       06600       PHYSI CAL THERAPY       429, 420       22, 946, 275       0.018714       5, 448, 150       101, 957       66.00         67.00       06700       0CCUPATI ONAL THERAPY       4, 618       12, 338, 378       0.000374       4, 163, 673       1, 557       67.00         68.00       06800       SPEECH PATHOLOGY       3, 493       5, 007, 848       0.000698       980, 111       684       68.00         69.00       OF000       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 7	54. 01 05401 ULTRASOUND	0	0	0.0000	0 00	0	54.01
58.00         05800         MRI         0         0         0.000000         0         0         58.00           60.00         06000         LABORATORY         639,904         237,177,107         0.002698         40,864,675         110,253         60.00           65.00         06500         RESPI RATORY THERAPY         113,958         56,502,295         0.002017         26,608,366         53,669         65.00           66.00         06600         PHYSI CAL THERAPY         429,420         22,946,275         0.018714         5,488,150         101,957         66.00           67.00         06700         OCCUPATI ONAL THERAPY         4,618         12,338,378         0.000374         4,163,673         1,557         67.00           68.00         06800         SPEECH PATHOLOGY         3,493         5,007,848         0.000698         980,111         6844         68.00           69.00         06900         ELCCTROCARDI 0LOGY         980,924         172,572,171         0.005684         28,015,106         159,238         69.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         35,616         42,119,546         0.0001532         53,595,727         82,009         73.00         73.00         73.00	56. 00 05600 RADI OI SOTOPE	0	0	0.0000	0 0	0	56.00
60.00       06000       LABORATORY       639,904       237,177,107       0.002698       40,864,675       110,253       60.00         65.00       06500       RESPI RATORY THERAPY       113,958       56,502,295       0.002017       26,608,366       53,669       65.00         66.00       06600       PHYSI CAL THERAPY       429,420       22,946,275       0.018714       5,448,150       101,957       66.00         67.00       06700       OCCUPATI ONAL THERAPY       4,618       12,338,378       0.000374       4,163,673       1,557       67.00         68.00       06800       SPEECH PATHOLOGY       3,493       5,007,848       0.000698       980,111       684       68.00         69.00       D6900       ELECTROCARDI OLOGY       980,924       172,572,171       0.005684       28,015,106       159,238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35,616       42,119,546       0.000846       9,109,395       7,707       71.00         72.00       07200       IMPL.       DEV.       CHARGED TO PATI ENTS       298,158       194,655,208       0.001532       53,595,727       82,109       72.00         74.00       07400       RENAL DI ALYSI S	57.00 05700 CT SCAN	0	0	0.0000	0 00	0	57.00
65.00       06500       RESPI RATORY THERAPY       113, 958       56, 502, 295       0.002017       26, 608, 366       53, 669       65.00         66.00       06600       PHYSI CAL THERAPY       429, 420       22, 946, 275       0.018714       5, 448, 150       101, 957       66.00         67.00       06700       OCCUPATI ONAL THERAPY       4, 618       12, 338, 378       0.000374       4, 163, 673       1, 557       67.00         68.00       06800       SPEECH PATHOLOGY       3, 493       5, 007, 848       0.000698       980, 111       68.48.00         69.00       06900       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35, 616       42, 119, 546       0.000846       9, 109, 395       7, 707       71.00         72.00       07200       IMPL       DEV. CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 93       74.00         76.00       03950       ANCI LLARY	58. 00 05800 MRI	0	0	0.0000	0 0	0	58.00
66.00       06600       PHYSI CAL THERAPY       429, 420       22, 946, 275       0.018714       5, 448, 150       101, 957       66.00         67.00       06700       OCCUPATI ONAL THERAPY       4, 618       12, 338, 378       0.000374       4, 163, 673       1, 557       67.00         68.00       06800       SPEECH PATHOLOGY       3, 493       5, 007, 848       0.000698       980, 111       684       68.00         69.00       06900       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35, 616       42, 119, 546       0.000846       9, 109, 395       7, 707       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         73.00       07400       RENAL DI ALYSIS       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       0       76.01         0.3051       WOUND CARE       220, 631       11, 740, 219	60. 00 06000 LABORATORY	639, 904	237, 177, 107	0.0026	98 40, 864, 675	110, 253	60.00
67.00       06700       0CCUPATI ONAL THERAPY       4, 618       12, 338, 378       0.000374       4, 163, 673       1, 557       67.00         68.00       06800       SPEECH PATHOLOGY       3, 493       5, 007, 848       0.000698       980, 111       684       68.00         69.00       06900       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35, 616       42, 119, 546       0.000846       9, 109, 395       7, 707       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         73.00       07400       RENAL DI ALYSIS       228, 114       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEP LAB       0       0       0.000000       0       0       76.03         09.00       09000       CLINIC       0       0       0.000000       0	65. 00 06500 RESPI RATORY THERAPY	113, 958	56, 502, 295	0.0020	17 26, 608, 366	53, 669	65.00
68.00       06800       SPEECH PATHOLOGY       3, 493       5, 007, 848       0.000698       980, 111       684       68.00         69.00       06900       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35, 616       42, 119, 546       0.000846       9, 109, 395       7, 707       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.002575       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEP LAB       0       0       0.000000       0       0       76.01         76.03       03951       WOUND CARE       220, 631       11, 740, 219       0.18793	66. 00 06600 PHYSI CAL THERAPY	429, 420	22, 946, 275	0. 0187	14 5, 448, 150	101, 957	66.00
69.00       06900       ELECTROCARDI OLOGY       980, 924       172, 572, 171       0.005684       28, 015, 106       159, 238       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       35, 616       42, 119, 546       0.000846       9, 109, 395       7, 707       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       298, 158       194, 655, 208       0.001242       30, 047, 335       37, 319       73.00         74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       76.01         76.03       03951       WOUND CARE       220, 631       11, 740, 219       0.018793       182, 712       3, 434         76.03       03951       WOUND CARE       0       0       0.000000       0       90.00	67.00 06700 OCCUPATI ONAL THERAPY	4, 618	12, 338, 378	0.0003	74 4, 163, 673	1, 557	67.00
71. 00         07100         MEDI CAL         SUPPLI ES         CHARGED TO PATI ENT         35, 616         42, 119, 546         0.000846         9, 109, 395         7, 707         71. 00           72. 00         07200         IMPL.         DEV.         CHARGED TO PATI ENTS         298, 158         194, 655, 208         0.001532         53, 595, 727         82, 109         72. 00           73. 00         07300         DRUGS         CHARGED TO PATI ENTS         361, 197         290, 899, 260         0.001242         30, 047, 335         37, 319         73. 00           74. 00         07400         RENAL DI ALYSI S         22, 811         4, 324, 287         0.005275         2, 256, 488         11, 903         74. 00           76. 00         03950         ANCI LLARY         0         0         0.000000         0         0         76. 01           76. 01         03610         SLEEP LAB         0         0         0.000000         0         0         76. 01           76. 03         03951         WOUND CARE         200, 631         11, 740, 219         0.018793         182, 712         3, 434         76. 03           00TPATI ENT SERVICE COST CENTERS         0         0         0.000000         0         0         90. 00 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>3, 493</td> <td>5, 007, 848</td> <td>0.0006</td> <td>980, 111</td> <td>684</td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	3, 493	5, 007, 848	0.0006	980, 111	684	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       298, 158       194, 655, 208       0.001532       53, 595, 727       82, 109       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       361, 197       290, 899, 260       0.001532       30, 047, 335       37, 319       73.00         74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       76.01         76.03       03951       WOUND CARE       200, 631       11, 740, 219       0.018793       182, 712       3, 434         76.03       09000       CLI NI C       0       0       0.000000       0       90.00         90.00       09000       CLI NI C       0       0       0.007533       24, 769, 407       186, 588       91.00         91.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       354, 335       17, 397, 757       0.020367       2, 752, 640       56, 063       92.00	69. 00 06900 ELECTROCARDI OLOGY	980, 924	172, 572, 171	0.00568	28, 015, 106	159, 238	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       361, 197       290, 899, 260       0.001242       30, 047, 335       37, 319       73.00         74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       76.01         76.03       03951       WOUND CARE       220, 631       11, 740, 219       0.018793       182, 712       3, 434         76.03       09000       CLI NI C       0       0       0.000000       0       90.00         90.00       09000       CLI NI C       0       0.000000       0       90.00       90.00         91.00       09100       EMERGENCY       1, 480, 465       196, 543, 266       0.007533       24, 769, 407       186, 588       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       354, 335       17, 397, 757       0.020367       2, 752, 640       56, 063       92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 616	42, 119, 546	0.00084	46 9, 109, 395	7, 707	71.00
74.00       07400       RENAL DI ALYSI S       22, 811       4, 324, 287       0.005275       2, 256, 488       11, 903       74.00         76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       0       76.01         76.03       03951       WOUND CARE       220, 631       11, 740, 219       0.018793       182, 712       3, 434       76.03         00TPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       90.00         90.00       09000       CLI NI C       0       0.000000       0       90.00       90.00         91.00       09100       EMERGENCY       1, 480, 465       196, 543, 266       0.007533       24, 769, 407       186, 588       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       354, 335       17, 397, 757       0.020367       2, 752, 640       56, 063       92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	298, 158	194, 655, 208	0.00153	32 53, 595, 727	82, 109	72.00
76.00       03950       ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03610       SLEEP LAB       0       0       0       0.000000       0       0       76.01         76.03       03951       WOUND CARE       220, 631       11, 740, 219       0.018793       182, 712       3, 434       76.03         00TPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       90.00       90000       CLI NI C       90.00 <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>361, 197</td> <td>290, 899, 260</td> <td>0.00124</td> <td>42 30, 047, 335</td> <td>37, 319</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	361, 197	290, 899, 260	0.00124	42 30, 047, 335	37, 319	73.00
76.00       03950       ANCI LLARY       0       0       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0       0       76.01         76.02       03951       WOUND CARE       220,631       11,740,219       0.018793       182,712       3,434       76.03         00       09000       CLI NI C       0       0       0.000000       0       90.00         90.00       09000       CLI NI C       0       0       0.000000       0       90.00         91.00       09100       EMERGENCY       1,480,465       196,543,266       0.007533       24,769,407       186,588       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       354,335       17,397,757       0.020367       2,752,640       56,063       92.00	74.00 07400 RENAL DIALYSIS	22, 811	4, 324, 287	0.0052	2, 256, 488	11, 903	74.00
76. 03         03951         WOUND_CARE         220, 631         11, 740, 219         0.018793         182, 712         3, 434         76. 03           0UTPATI ENT_SERVICE_COST_CENTERS         0         0         0.000000         0         0         90. 00         90.00         90.00         0         90. 00	76. 00 03950 ANCI LLARY	0	0	0.0000	0 00		
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         0         0.000000         0         090.00           91.00         09100         EMERGENCY         1, 480, 465         196, 543, 266         0.007533         24, 769, 407         186, 588         91.00           92.00         09200         OBSERVATI ON_BEDS_(NON-DI STINCT_PART         354, 335         17, 397, 757         0.020367         2, 752, 640         56, 063         92.00	76.01 03610 SLEEP LAB	0	0	0.0000	0 00	0	76.01
90. 00         09000         CLINIC         0         0.00000         0         0         90. 00           91. 00         09100         EMERGENCY         1, 480, 465         196, 543, 266         0.007533         24, 769, 407         186, 588         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DISTINCT PART         354, 335         17, 397, 757         0.020367         2, 752, 640         56, 063         92. 00	76.03 03951 WOUND CARE	220, 631	11, 740, 219	0. 01879	93 182, 712	3, 434	76.03
91. 00         09100         EMERGENCY         1, 480, 465         196, 543, 266         0. 007533         24, 769, 407         186, 588         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         354, 335         17, 397, 757         0. 020367         2, 752, 640         56, 063         92. 00	OUTPATIENT SERVICE COST CENTERS						1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 354, 335 17, 397, 757 0. 020367 2, 752, 640 56, 063 92. 00	90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 354, 335 17, 397, 757 0. 020367 2, 752, 640 56, 063 92. 00	91. 00 09100 EMERGENCY	1, 480, 465	196, 543, 266	0.00753	33 24, 769, 407	186, 588	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	354, 335					92.00
							200. 00

31. 00       03100       INTENSIVE CARE UNIT       0       0       0       0       0       31         31. 01       03101       INCONATAL INTENSIVE CARE UNIT       0       0       0       0       0       31         41. 00       QUATION       SUBROVIDER - IRF       0 <t< th=""><th>Health Financial Systems</th><th>PORTER MEMORI</th><th>AL HOSPITAL</th><th></th><th>In Lie</th><th>eu of Form CMS-</th><th>2552-10</th></t<>	Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
Cost Center Description         Nursing School Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Cost         All other Medical Education Cost           30.00         03000 ADULTS & PEDIATRICS         0 <td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER</td> <td>PASS THROUGH COS</td> <td></td> <td></td> <td>From 01/01/2019 To 12/31/2019</td> <td>Part III Date/Time Pre 8/18/2020 12:</td> <td></td>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			From 01/01/2019 To 12/31/2019	Part III Date/Time Pre 8/18/2020 12:	
Post-Stepdown Adjustments         Cost         Medical Education Cost           1NPATI ENT ROUTINE SERVICE COST CENTERS         1.00         2A         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0 <td< td=""><td></td><td></td><td>Title</td><td>e XVIII</td><td>Hospi tal</td><td>PPS</td><td></td></td<>			Title	e XVIII	Hospi tal	PPS	
Adjustments         Adjustments         Education Cost           1A         1.00         2A         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0	Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
INPATI ENT ROUTINE SERVICE COST CENTERS         0         2A         2.00         3.00           30.00         03000 (ADULTS & PEDIATRICS         0		Post-Stepdown	-	Post-Stepdowr	n Cost	Medi cal	
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS         0		Adjustments		Adjustments		Education Cost	
30.00       03000       ADULTS & PEDIATRICS       0       0       0       0       0       0       0       0       0       0       0       31.00       0		1A	1.00	2A	2.00	3.00	
31.00       03100       INTENSIVE CARE UNIT       0       0       0       0       0       31       01       03101       NEONATAL INTENSIVE CARE UNIT       0       0       0       0       0       31       01       03101       NEONATAL INTENSIVE CARE UNIT       0<	INPATIENT ROUTINE SERVICE COST CENTERS						
31.01       03101       NEONATAL INTENSIVE CARE UNIT       0	30. 00 03000 ADULTS & PEDI ATRI CS	0	0	)	0 0	0	30.00
41.00       04100       SUBPROVIDER - IRF       0<	31.00 03100 INTENSIVE CARE UNIT	0	l o		o o	0	31.00
41.00       04100       SUBPROVIDER - IRF       0<	31.01 03101 NEONATAL INTENSIVE CARE UNIT	0			0 0	0	31.01
43.00         04300         NURSERY         0		0	0		0 0	0	
200.00         Total (lines 30 through 199)         0		0			0 0	0	1
Cost Center Description         Swing-Bed Adjustment Amount (see instructions)         Total Costs (sum of cols. 1 through 3, instructions)         Total Patient Days         Per Diem (col. 5 ÷ col. 6)         Inpatient Program Days           30.00         0000 ADULTS & PEDI ATRICS         0         0.00         5.00         6.00         7.00         8.00           31.00         03000 ADULTS & PEDI ATRICS         0         0         5,925         0.00         2,865         31           31.01         03101 INEONATAL INTENSIVE CARE UNIT         0         2,827         0.00         2,865         31           41.00         04300 PURSERY         0         0,2,638         0.00         0         4.817         200           200.00         Total (Lines 30 through 199)         Inpatient Program Pass-Through Cost (col. 7 x col. 8)         0         24,817         200           0         03000 ADULTS & PEDI ATRICS         0         30.00         24,817         200           0         0         0         3,152         0.00         24,817         200           0         0         0         0         66,701         24,817         200           0         0         3000         ADULTS & PEDI ATRICS         0         30         30		0			0 0	j ő	200.00
Adj ustment Amount (see instructions)         Days         5 ÷ col. 6)         Program Days           1 through 3, instructions)         1 through 3, instructions)         0         5 ÷ col. 6)         Program Days           30.00         03000 ADULTS & PEDIATRICS         0         0         5.00         6.00         7.00         8.00           31.00         03000 ADULTS & PEDIATRICS         0         0         5.2,159         0.00         19,806         30           31.00         03100 INTENSI VE CARE UNIT         0         5,925         0.00         2,865         31           31.01         03101 NEONATAL INTENSI VE CARE UNIT         0         2,827         0.00         0         31           43.00         04300         NURSERY         0         2,638         0.00         0         4.80           200.00         Total (Lines 30 through 199)         Inpati ent Program         Program         24,817         200           Cost Center Description         Inpati ent Program         Pass-Through Cost (col. 7 x col. 8)         9.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.01         31.01         31.01         31.01         31.01         31.01 <td></td> <td>Swing-Bed</td> <td>Total Costs</td> <td>Total Patient</td> <td>Per Diem (col</td> <td></td> <td>200.00</td>		Swing-Bed	Total Costs	Total Patient	Per Diem (col		200.00
Amount (see instructions)         1 through 3, minus col. 4)         3 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
INPATI ENT ROUTI NE SERVI CE COST CENTERS         mi nus col. 4)         0         5.00         6.00         7.00         8.00           30.00         03000 ADULTS & PEDIATRI CS         0         0         5.00         6.00         7.00         8.00           31.00         03100 INTENSI VE CARE UNI T         0         5.925         0.00         2.865         31           31.01         03101 NEONATAL INTENSI VE CARE UNI T         0         2.827         0.00         0         31           41.00         SUBPROVI DER - I RF         0         0         3,152         0.00         2,485         31           200.00         Total (Lines 30 through 199)         0         66,701         24,817         200           Cost Center Description         Inpati ent Program Pass-Through Cost (col. 7 x col. 8)         9.00         31.00         3000 ADULTS & PEDIATRI CS         0         31.00         31.01         03000 ADULTS & PEDIATRI CS         0         31.01         31.01         3101 INTENSIVE CARE UNI T         0         31.01         31.01         3101         8 PEDIATRI CS         0         31.01				Julio			
4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDIATRICS         0         0         52,159         0.00         19,806         30           31.01         03100         INTENSI VE CARE UNIT         0         5,925         0.00         2,865         31           31.01         03101         NEONATAL INTENSI VE CARE UNIT         0         2,827         0.00         0         31           41.00         04100         SUBPROVI DER - IRF         0         0         3,152         0.00         2,485           200.00         Total (Lines 30 through 199)         0         66,701         24,817         200           Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8)         9.00         310           30.00         03000 ADULTS & PEDIATRICS         0         310							
INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDI ATRICS         0         0         52, 159         0.00         19, 806         30           31.00         03100         INTENSI VE CARE UNI T         0         5, 925         0.00         2, 865         31           31.01         03101         NEONATAL INTENSI VE CARE UNI T         0         2, 827         0.00         0         31, 152         0.00         2, 146         41           41.00         O4100         SUBPROVI DER - I RF         0         0         3, 152         0.00         2, 146         43           200.00         Total (Lines 30 through 199)         0         66, 701         24, 817         200           Cost Center Description         Inpati ent Program Pass-Through Cost (col. 7 x col.8)         9.00         31         31         31.00         03000         ADULTS & PEDI ATRICS         31         31         31.00         03100         INPATI ENT ROUTI NE SERVICE COST CENTERS         30         00         3100         31         31         31         31         31         31         31         31         31         31         31         31         31         31         31         31         31 <td< td=""><td></td><td></td><td></td><td>6.00</td><td>7 00</td><td>8.00</td><td></td></td<>				6.00	7 00	8.00	
30.00       03000       ADULTS & PEDIATRICS       0       0       52, 159       0.00       19, 806       30         31.00       03100       INTENSI VE CARE UNIT       0       5, 925       0.00       2, 865       31         31.01       03101       NEONATAL INTENSI VE CARE UNIT       0       2, 827       0.00       0       31         41.00       04100       SUBPROVIDER - IRF       0       0       3, 152       0.00       2, 146       41         43.00       04300       NURSERY       0       2, 638       0.00       0       43         200.00       Total (Lines 30 through 199)       0       66, 701       24, 817       200         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       24, 817       200         30.00       03000       ADULTS & PEDIATRICS       0       31         31.00       03000       ADULTS & PEDIATRICS       0       31       31         31.01       03101       NEONATAL INTENSI VE CARE UNIT       0       31       31	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
31.00       03100       INTENSIVE CARE UNIT       0       5,925       0.00       2,865       31         31.01       03101       NEONATAL INTENSIVE CARE UNIT       0       2,827       0.00       0       31         41.00       04100       SUBPROVIDER - IRF       0       0       3,152       0.00       2,146       41         43.00       04300       NURSERY       0       2,638       0.00       0       43         200.00       Total (lines 30 through 199)       0       66,701       24,817       200         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       9.00       31         NPATI ENT ROUTINE SERVICE COST CENTERS         30.00       03000       ADULTS & PEDIATRICS       0       31         31.01       03101       NEONATAL INTENSIVE CARE UNIT       0       31         31.01       03101       NEONATAL INTENSIVE CARE UNIT       0       31		0	0	52 15	9 0.00	19 806	30.00
31.01       03101       NEONATAL INTENSIVE CARE UNIT       0       2,827       0.00       0       31         41.00       04100       SUBPROVIDER - IRF       0       0       3,152       0.00       2,146       41         43.00       04300       NURSERY       0       2,638       0.00       0       43         200.00       Total (lines 30 through 199)       0       66,701       24,817       20         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       43       43       44       44       44       44       44       44       44       44       44       44       45							
41.00       04100       SUBPROVI DER - I RF       0       0       3,152       0.00       2,146       41         43.00       04300       NURSERY       0       2,638       0.00       0       43         200.00       Total (Lines 30 through 199)       0       66,701       24,817       200         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       24,817       200         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000       ADULTS & PEDIATRICS       0       30         31.00       03100       INTENSIVE CARE UNIT       0       31       31							•
43.00       04300       NURSERY       0       2,638       0.00       0       43         200.00       Total (Lines 30 through 199)       0       66,701       24,817       200         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       0       43         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000       ADULTS & PEDIATRICS       0       31         31.01       03101       NEONATAL INTENSIVE CARE UNIT       0       31		0					
200.00         Total (lines 30 through 199)         0         66,701         24,817         200           Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8)         9.00         1<		0					
Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)         30.00       03000         ADULTS & PEDIATRICS       0         31.00       03100         INTENSI VE CARE UNIT       0         31.01       03101							
INPATI ENT ROUTI NE SERVI CE COST CENTERS       30.00     03000     ADULTS & PEDI ATRI CS     0       31.00     03100     INTENSI VE CARE UNI T     0       31.01     03101     NEONATAL INTENSI VE CARE UNI T     0		Innationt	0	00,70	1	24, 017	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS     Pass-Through Cost (col. 7 x col. 8)     9.00       30.00     03000     ADULTS & PEDI ATRI CS     0       31.00     03100     INTENSI VE CARE UNI T     0       31.01     03101     NEONATAL INTENSI VE CARE UNI T     0	cost center bescription						
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         30.00         03000 ADULTS & PEDI ATRI CS         0         31.00         31.00         03100 INTENSI VE CARE UNI T         0         31.01         03101 NEONATAL INTENSI VE CARE UNI T         0         31.01         31.01         31.01         03101 NEONATAL INTENSI VE CARE UNI T         0         31.01							
col. 8)         9.00           INPATIENT ROUTINE SERVICE COST CENTERS         30.00           30.00         03000 ADULTS & PEDIATRICS         0           31.00         03100         INTENSI VE CARE UNIT         0           31.01         03101         NEONATAL INTENSI VE CARE UNIT         0							
9.00           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         0         30           31.00         03100         INTENSI VE CARE UNIT         0         31           31.01         03101         NEONATAL INTENSI VE CARE UNIT         0         31							
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         0         30           31.00         03100         INTENSIVE CARE UNIT         0         31           31.01         03101         NEONATAL INTENSIVE CARE UNIT         0         31							
30. 00         03000         ADULTS & PEDIATRICS         0         30           31. 00         03100         INTENSI VE CARE UNIT         0         31           31. 01         03101         NEONATAL INTENSI VE CARE UNIT         0         31	INDATIENT DOUTINE SEDVICE COST CENTERS	9.00		-			-
31.00         03100         INTENSIVE CARE UNIT         0         31           31.01         03101         NEONATAL INTENSIVE CARE UNIT         0         31							30.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT 0 31		0					
		0					31.00
41 00 1041001NUBPROVIDER - TRE ()		0					31.01
		0					41.00
		0					43.00
200.00 Total (lines 30 through 199) 0 200	200.00   lotal (lines 30 through 199)	0					200.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	_	Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C	)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	c c		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	l c		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	l c		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	l c		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	l c		0 0	0	56.00
57. 00 05700 CT SCAN	0	l c		0 0	0	57.00
58. 00 05800 MRI	0	l c		0 0	0	58.00
60. 00 06000 LABORATORY	0			0 0	0	1
65. 00 06500 RESPIRATORY THERAPY	0			0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0			0 0	0	
68.00 06800 SPEECH PATHOLOGY	0			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	
74. 00 07400 RENAL DIALYSIS	0			0 0	0	
76. 00 03950 ANCI LLARY	0			0 0	0	1
76. 01 03610 SLEEP LAB	0			0 0	0	
76. 03 03951 WOUND CARE	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>		/0.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	l c		0 0	-	200.00
	1 0	1 0	.1	SI 0	1 0	1-00.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CON: 15-0035         Period: Period: To 12/31/2019         Period: Period: Period: To 12/31/2019         Worksheet D Period: Peri	Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Ancount obside         To         12/31/2019         Date:Time Prepared: BATE:Time Prepared: BAT		RVICE OTHER PAS	S Provider C	CN: 15-0035			
Anci ILLARY SERVICE COST CENTERS         All Other Education Cost         Total Cost (sum of cols. 1, 2, 3, and 4)         Total Cost (sum of cols. 1, 2, 3, and 4)         Total Cost (sum of cols. 1, 2, 3, and 4)         Total Charges (rol s. 2, 3, and 4)         Total Charges (rol s. 2, 4, 2, 3, and 4) <th< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td></td><td>narod</td></th<>	THROUGH COSTS						narod
Cost Center Description         All Other Medical Education Cost (sum of cols. 4)         Total Outpatient (sum of cols. (sum of cols. 2, 3, and 4)         Total Outpatient (cols. 2, 3, and 4)         Total (cols. 2, 3, and 4)         Charges (sol. 5 + col. 8)           ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000 0PERATING R00M         0         0         0         0.000000         50.00           51.00         05000 APERATING R00M         0         0         0         0         0.000000         50.00           52.00         05200 APERATING R00M         0         0         0         0.000000         50.00           53.00         05300 APESTHESIOLOGY         0         0         0         0.000000         50.00           54.00         05401 RATING R00M         0         0         0         0.000000         54.00           55.00         05000 RADIOLOGY-DIAGNOSTIC         0         0         0         0.000000         54.00           56.00         05000 CLASORATORY         0         0         0         0.000000         54.00           56.00         05000 CLASORATORY         0         0         0         0         0.000000         58.00					10 12/31/2019		
Medical Education Cost         Sum of cols. (a)         Outpatient (ost (sum of a))         (from Wkst) C (see and 4)         to tharges (col (s - 5 + col) a)           ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000 (PERATI NG ROOM 5000 (PERATI NG ROOM 5000 (PERATI NG ROOM 51.00         0         0         0         0         0         0.000000         50.							
Education Cost         1, 2, 3, and 4)         2, 3, and 4)         Part 1, col. col s. 2, 3, and 4)         Part 1, col. 8)         Col. 5, col. 7)         Col. 7)           ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           MACI LLARY SERVICE COST CENTERS         0         0         0         383,918,687         0.000000         50.00           50.00         05000 (DPENATI NC ROOM         0         0         0         0         0         0.000000         50.00           51.00         05300 ANESTHESI OLOGY         0         0         0         0.000000         52.00         53.00         05300 ANESTHESI OLOGY         0         0         0.000000         53.00         53.00         05300 ANESTHESI OLOGY         0         0         0.000000         54.00         54.00         54.00         54.00         54.00         56.00         0         0.000000         54.00         55.00         05600 RADI OLOGY-DI AGNOSTI C         0         0         0         0.000000         54.00         55.00         05600 RADI OLOGY-DI AGNOSTI C         0         0         0.000000         57.00         57.00         55.00         0.000000         56.00         57.00         55.00         57.00         57.00	Cost Center Description						
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         0PERATING ROOM         0         0         383,918,687         0.000000         50.00           50.00         05000         0PERATING ROOM         0         0         383,918,687         0.000000         50.00           51.00         05100         RCOVERY ROOM         0         0         0         0         0.000000         51.00           52.00         05200         DELIVERY ROOM         0         0         0         0.000000         52.00         0         0.000000         52.00         0         0.000000         52.00         0         0.000000         52.00         0         0.000000         52.00         0         0.000000         53.00         0.000000         54.00         0         0         0         0.000000         54.00         56.00         56.00         0.000000         54.00         0         0         0.000000         54.00         56.00         56.00         56.00         56.00         56.00         0         0.000000         54.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00							
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           ANCI LLARY SERVICE COST CENTERS         0         0         0.383,918,687         0.000000         51.00           51.00         05000 [PERATI NG ROOM         0         0         0         0.000000         51.00           52.00         05200 [DELIVERY ROOM & LABOR ROOM         0         0         0         16.483,028         0.000000         52.00           53.00         05300 ANESTHESI OLOGY         0         0         0         264,510,943         0.000000         53.00           54.01         05400 [RADI OLOGY-DI ARNOSTI C         0         0         0         0.000000         54.01           55.00         05500 [RI SCRAUMID         0         0         0         0.000000         54.01           54.01         05400 [RADI OLOGY-DI ARNOSTI C         0         0         0         0.000000         54.01           55.00         05500 [RI SCRAUMID         0         0         0         0.000000         54.01           56.00         05600 [RSPI RATORY         0         0         0         0.000000         58.00           60.00         06000 [RSPI RATORY THERAPY         0 <td< td=""><td></td><td>Education Cost</td><td></td><td></td><td></td><td></td><td></td></td<>		Education Cost					
ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00           50.00         05000         0PERATI NG ROOM         0         0         383.918.687         0.000000         50.00           51.00         05100         RCEVERY ROOM         0         0         0         0.000000         50.00           52.00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         0.000000         52.00           53.00         05300         MESTHESI OLGOY         0         0         0         264.510.943         0.000000         52.00           54.00         05400         RADI LLARY SERVICE         0         0         0         0.000000         54.00           54.01         05401         RUTRASOUND         0         0         0         0.000000         54.00           56.00         05700 CT SCAN         0         0         0         0.000000         55.00           66.00         DAGON LARATORY         0         0         0         0.000000         55.00           66.00         OS700 CT SCAN         0         0         0         0.000000         58.00           66.00         D6500 RADI INALTHERAPY         0			4)		8)		
ANCI LLARY SERVICE COST CENTERS				and 4)			
ANCILLARY SERVICE COST CENTERS         0 <th< td=""><td></td><td>4.00</td><td>5.00</td><td>6.00</td><td>7.00</td><td></td><td></td></th<>		4.00	5.00	6.00	7.00		
50.00       05000       DPERATING R00M       0       0       383,918,687       0.000000       50.00         51.00       05100       RECVERY R00M       0       0       0       0.000000       51.00         52.00       DELIVERY R00M & LABOR R00M       0       0       0       0.000000       52.00         53.00       05300       ANESTHESI 0LOGY       0       0       0       26,579,329       0.000000       53.00         54.01       05401       VLTRASOUND       0       0       0       0.000000       54.01         55.00       05400       RADI 0LOGY-DI AGNOSTI C       0       0       0       0.000000       54.01         54.01       05401       ULTRASOUND       0       0       0       0.000000       54.01         55.00       05500       RADI 0LOGY-DI AGNOSTI C       0       0       0       0.000000       54.01         56.00       05600       RADI 0LOGY-DI AGNOSTI C       0       0       0       0.000000       56.00         57.00       05700       CT SCAN       0       0       0       0       0.000000       58.00         60.00       05600 RESPI RATORY THERAPY       0       0	ANCILLARY SERVICE COST CENTERS	4.00	0.00	0.00	7.00	0.00	
51.00       05100       RECOVERY ROOM       0       0       0       0.000000       51.00         52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       16,483,028       0.000000       52.00         53.00       OS300       ANESTHESI OLOGY       0       0       0       20,579,329       0.000000       53.00         54.00       O5400       RADI OLOGY-DI AGNOSTI C       0       0       0       0.000000       54.00         54.01       O5401       ULTRASOUND       0       0       0       0.000000       54.01         54.01       O5401       ILTRASOUND       0       0       0       0.000000       54.00         54.01       O5401       OLI STOPE       0       0       0       0.000000       56.00         55.00       O5500       RAI OLSOTPE       0       0       0       0.000000       56.00         56.00       O500       RESPI RATORY THERAPY       0       0       0       0.000000       58.00         66.00       O6500       RESPI RATORY THERAPY       0       0       0       12,33,378       0.000000       67.00         66.00       O6600       PHYSI CAL THERAPY		0	0		0 383, 918, 687	0,00000	50.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       16,483,028       0.000000       52.00         53.00       05300       ANESTHESI OLOGY       0       0       0       20,579,329       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       264,510,943       0.000000       54.01         54.01       05401       IULTRASOUND       0       0       0       0.000000       54.01         56.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0.000000       54.01         57.00       05400       RADI OLSOTOPE       0       0       0       0.000000       56.00         58.00       05500       RADRATORY       0       0       0       0.000000       58.00         66.00       06500       RESPI RATORY THERAPY       0       0       0       237,177,107       0.000000       66.00         67.00       06500       RESPI RATORY THERAPY       0       0       12,338,378       0.000000       67.00         68.00       06800       SPECH PATHOLOGY       0       0       12,338,378       0.000000       69.00       71.00		0	0				
54.00       05400       RADI 0L0GY-DI AGNOSTI C       0       0       264, 510, 943       0.000000       54.00         54.01       05401       JULTRASOUND       0       0       0       0.000000       54.01         56.00       RADI 0I SOTOPE       0       0       0       0.000000       54.01         57.00       05700       CT SCAN       0       0       0.000000       57.00         58.00       05800       MRI       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       58.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       22, 946, 275       0.000000       66.00         66.00       0600       PHYSI CAL THERAPY       0       0       0       12, 338, 378       0.000000       67.00         68.00       SPEECH PATHOLOGY       0       0       0       12, 338, 378       0.000000       69.00         71.00       0K800       SPEECH PATHOLOGY       0       0       12, 52, 171       0.000000       69.00         71.00       0K900       CLATARSCUPAL DATHERAPY       0       0 <td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td> <td>0</td> <td>0</td> <td></td> <td>0 16, 483, 028</td> <td>0.000000</td> <td></td>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 16, 483, 028	0.000000	
54. 01       05401       ULTRASOUND       0       0       0       0.000000       54. 01         55. 00       05600       RADI 0I SOTOPE       0       0       0       0.000000       56. 00         57. 00       05600       CT SCAN       0       0       0       0.000000       57. 00         58. 00       05800       MRI       0       0       0       0.000000       58. 00         60. 00       06000       LABORATORY       0       0       0       0.000000       65. 00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0.000000       65. 00         66.00       06600       PHYSI CAL THERAPY       0       0       0       22, 946, 275       0.000000       66. 00         67. 00       06700       CCUPATI ONAL THERAPY       0       0       0       5, 007, 848       0.000000       68. 00         68. 00       06900       ELECTROCARDI DLOGY       0       0       172, 572, 171       0.000000       68. 00         71. 00       07100       MEI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       194, 655, 208       0.000000       71. 00         72. 00       07400 <td>53. 00 05300 ANESTHESI OLOGY</td> <td>0</td> <td>0</td> <td></td> <td>0 20, 579, 329</td> <td>0. 000000</td> <td>53.00</td>	53. 00 05300 ANESTHESI OLOGY	0	0		0 20, 579, 329	0. 000000	53.00
56.00         05600         RADI 0I SOTOPE         0         0         0.000000         56.00           57.00         05700         CT SCAN         0         0         0         0.000000         57.00           58.00         05800         MRI         0         0         0         0.000000         58.00           60.00         06400         LABORATORY         0         0         0         0.000000         65.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         56.00         66.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         22,946,275         0.000000         67.00           67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         50.07,848         0.000000         68.00           68.00         06800         SPECH PATHOLOGY         0         0         0         172,572,171         0.000000         69.00           71.00         MTIO MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         194,655,208         0.000000         73.00           73.00         OT400         RENAL DI ALYSI S         0         0         0 <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>0</td> <td></td> <td>0 264, 510, 943</td> <td>0. 000000</td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 264, 510, 943	0. 000000	54.00
57.00       05700       CT SCAN       0       0       0       0.000000       57.00         58.00       05800       MRI       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       58.00         60.00       06000       LABORATORY       0       0       0       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       22,946,275       0.000000       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       12,338,378       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       12,338,378       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       12,572,171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       42,19,546       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       194,655,208       0.000000       73.00         74.00	54. 01 05401 ULTRASOUND	0	0		0 0	0. 000000	54.01
58.00       05800       MRI       0       0       0       0.00000       58.00         60.00       06000       LABORATORY       0       0       0       237, 177, 107       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       56, 502, 295       0.000000       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       12, 338, 378       0.000000       66.00         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       12, 338, 378       0.000000       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       5, 007, 848       0.000000       67.00         69.00       06900       ELCTROCARDI OLOGY       0       0       172, 572, 171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       142, 455, 268       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0.000000       73.00         74.00       07400       RENAL DI ALSYSIS       0       0	56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0. 000000	56.00
60.00       06000       LABORATORY       0       0       237, 177, 107       0.00000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       56, 502, 295       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       22, 946, 275       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       12, 338, 378       0.000000       67.00         68.00       SPEECH PATHOLOGY       0       0       0       5, 07, 848       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       172, 572, 171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       172, 572, 171       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       194, 655, 208       0.000000       72.00         74.00       07400       REMAL DI ALYSI S       0       0       0       0.000000       74.00         76.01       03610       SLEEP LAB       0       0       0       0       0.000000		0	0		0 0	0.000000	
65.00       06500       RESPI RATORY THERAPY       0       0       56, 502, 295       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       22, 946, 275       0.000000       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0       12, 338, 378       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       5, 007, 848       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       172, 572, 171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       42, 119, 546       0.000000       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       0       290, 899, 260       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       0.000000       76.00         76.01       03610       SLEP LAB       0       0       0       0.000000       76.00         76.03       03951       WOUND CARE       0       0       0       0		0	0		0 0	0.000000	
66.00       06600       PHYSI CAL THERAPY       0       0       22,946,275       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0       12,338,378       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       5,007,848       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       172,572,171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       42,119,546       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       194,655,208       0.000000       73.00         73.00       07300       DRUSS CHARGED TO PATI ENTS       0       0       290,899,260       0.000000       74.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       0       0.000000       74.00         76.01       03610       SLEEP LAB       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       <		0	0				
67.00       06700       OCUPATIONAL THERAPY       0       0       12,338,378       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       5,007,848       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       172,572,171       0.000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       42,119,546       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       194,655,208       0.000000       73.00         73.00       07300       DRUSS CHARGED TO PATIENTS       0       0       290,899,260       0.000000       73.00         74.00       07400       RENAL DIALYSIS       0       0       0       4,324,287       0.000000       74.00         76.01       03610       SLEEP LAB       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.03         00       0       0       0       0       0       0       0       0.000000		0	0				
68.00       06800       SPEECH PATHOLOGY       0       0       5,007,848       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       172,572,171       0.000000       69.00         71.00       07100       MEDI CAL       SUPPLIES       CHARGED TO PATIENT       0       0       42,119,546       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       194,655,208       0.000000       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       290,899,260       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       4,324,287       0.000000       74.00         76.00       03950       ANCI LLARY       0       0       0       0       0.000000       76.00         76.01       03610       SLEP LAB       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.03         00       0       0       0       0       0       0       0.000000		0	0				1
69.00       06900       ELECTROCARDI OLOGY       0       0       172, 572, 171       0.000000       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       42, 119, 546       0.000000       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       194, 655, 208       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       290, 899, 260       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       4, 324, 287       0.000000       74.00         76.00       03950       ANCI LLARY       0       0       0       0       0.000000       76.00         76.01       03610       SLEEP LAB       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.01         76.03       09000       CLINIC       0       0       0       0.000000       76.01 <tr< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>1</td></tr<>		0	0				1
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       42, 119, 546       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       194, 655, 208       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       290, 899, 260       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       4, 324, 287       0.000000       74.00         76.00       03950       ANCI LLARY       0       0       0       0       0.000000       76.00         76.01       03610       SLEEP LAB       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.01         76.00       09000       CLINIC       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       70.01         70.00		0	0				
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0         0         194,655,208         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         290,899,260         0.000000         73.00           74.00         07400         RENAL DI ALYSI S         0         0         0         4,324,287         0.000000         74.00           76.00         03950         ANCI LLARY         0         0         0         0         0.000000         76.00           76.01         03610         SLEEP LAB         0         0         0         0.000000         76.01           76.03         03951         WOUND CARE         0         0         0         0.000000         76.01           76.03         03951         WOUND CARE         0         0         0         0.000000         76.01           76.03         03951         WOUND CARE         0         0         0         0.000000         76.01           76.03         09000         CLINIC         0         0         0         0.000000         76.01           70.00         09000         CLINIC         0		0	0				
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       290, 899, 260       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       4, 324, 287       0.000000       74.00         76.00       03950       ANCI LLARY       0       0       0       0       0.000000       76.00         76.01       03610       SLEEP LAB       0       0       0       0.000000       76.01         76.03       03951       WOUND CARE       0       0       0       0.000000       76.01         76.04       03951       WOUND CARE       0       0       0       0.000000       76.01         76.05       03951       WOUND CARE       0       0       0       0.000000       76.01         76.05       017741ENT SERVICE COST CENTERS       0       0       0       0.000000       76.03         90.00       09000       CLI NI C       0       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       17, 397, 757       0.000000       92.00         92.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART		0	0				
74. 00       07400       RENAL DI ALYSI S       0       0       4, 324, 287       0.000000       74. 00         76. 00       03950       ANCI LLARY       0       0       0       0       0.000000       76. 00         76. 01       03610       SLEEP LAB       0       0       0       0       0.000000       76. 01         76. 01       03610       SLEEP LAB       0       0       0       0       0.000000       76. 01         76. 03       03951       WOUND CARE       0       0       0       0       0.000000       76. 01         76. 03       017PATI ENT SERVICE COST CENTERS       0       0       0       0       0.000000       76. 03         90. 00       09000       CLI NI C       0       0       0       0.000000       90. 00         91. 00       09100       EMERGENCY       0       0       0       196, 543, 266       0.000000       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       17, 397, 757       0.000000       92. 00		0	0				
76. 00       03950       ANCI LLARY       0       0       0       0       0.000000       76. 00         76. 01       03610       SLEEP LAB       0       0       0       0       0.000000       76. 01         76. 03       03951       WOUND CARE       0       0       0       0       11, 740, 219       0.000000       76. 03         00       0       0       0       0       0       0       0.000000       76. 03         01       017, 740, 219       0.000000       76. 03       0       0       0.000000       76. 03         01       00       00       0 <th< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></th<>		0					
76. 01         03610         SLEEP LAB         0         0         0         0.000000         76. 01           76. 03         03951         WOUND CARE         0         0         0         0         11, 740, 219         0.000000         76. 01           70. 00         0000         CLI NI C         0         0         0         0.000000         90. 00           91. 00         09100         EMERGENCY         0         0         0         196, 543, 266         0.000000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         17, 397, 757         0.000000         92. 00		0			4, 324, 287		
76. 03         03951         WOUND CARE         0         0         11, 740, 219         0.000000         76. 03           OUTPATI ENT SERVICE COST CENTERS         0         0         0         0.000000         90.00         90.00         90.00         90.00         90.00         90.00         90.000         90.00 <t< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td></td><td>1</td></t<>		0			0 0		1
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         0         0         0.00000         90.00           91.00         09100         EMERGENCY         0         0         0         196, 543, 266         0.000000         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         17, 397, 757         0.000000         92.00		0	0				
90. 00         09000         CLINIC         0         0         0         0.00000         90. 00         90. 00         90. 00         90. 00         91. 00         91. 00         91. 00         92. 00         09200         0BSERVATION         BEDS         (NON-DISTINCT PART         0         0         0         0         17, 397, 757         0. 000000         92. 00		0	0		0 11,740,219	0.000000	70.03
91. 00         09100         EMERGENCY         0         0         196, 543, 266         0. 00000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         17, 397, 757         0. 000000         92. 00		0	0		0 0	0,00000	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 17, 397, 757 0. 000000 92. 00		0	0				
		0	0				
		0	0				1

Health Financial Systems	PORTER MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0035	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
				To 12/31/2019		
		Title	XVIII	Hospi tal	8/18/2020 12: PPS	24 pm
Cost Center Description	Outpatient	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			•		•	
50.00 05000 OPERATI NG ROOM	0. 000000	62, 294, 971		0 63, 953, 293	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 891, 999		0 2, 738, 617	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	26, 807, 064		0 59, 610, 780	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	40, 864, 675		0 17, 067, 171	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	26, 608, 366		0 982, 591	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	5, 448, 150		0 117, 581	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 163, 673		0 54,007	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	980, 111		0 5, 506	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	28, 015, 106		0 40, 179, 747	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	9, 109, 395		0 4, 511, 813	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	53, 595, 727		0 29, 419, 941	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	30, 047, 335		0 89, 251, 041	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	2, 256, 488		0 46, 965	0	74.00
76. 00 03950 ANCI LLARY	0. 000000	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0. 000000	0		0 0	0	76.01
76.03 03951 WOUND CARE	0. 000000	182, 712		0 4, 530, 758	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	-	90.00
91. 00 09100 EMERGENCY	0. 000000	24, 769, 407		0 24, 816, 165		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	2, 752, 640		0 3, 324, 094		92.00
200.00   Total (lines 50 through 199)		320, 787, 819		0 340, 610, 070	0	200. 00

Health Financial Systems	PORTER MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCI NE COST	Provider C	CN: 15-0035	Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		pared.
					8/18/2020 12:	24 pm
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.)	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 072586	63, 953, 293	1	0 0	4, 642, 114	50.00
51. 00 05100 RECOVERY ROOM	0. 072588			0 0	4, 042, 114	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 315165			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 011921	2, 738, 617		0 0	32, 647	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 070612			0 0	4, 209, 236	
54. 01 05401 ULTRASOUND	0. 000000			0 0	4, 209, 230	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000			0 0		56.00
57. 00 05700 CT SCAN	0. 000000			0 0	0	57.00
58. 00  05800   MRI	0. 000000			0 0		58.00
60. 00 06000 LABORATORY	0. 000000			0 0	1, 283, 605	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 075209			0 0	69, 073	
66. 00 06600 PHYSI CAL THERAPY	0. 203648			0 0	23, 945	•
67. 00 06700 OCCUPATI ONAL THERAPY	0. 203848	54, 007		0 0	5, 582	
68. 00 06800 SPEECH PATHOLOGY	0. 202083			0 0	1, 113	
69. 00 06900 ELECTROCARDI OLOGY	0. 202083			0 0	2, 882, 214	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 087055			0 0	392, 776	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 135635			0 0	3, 990, 374	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 133033			0 187, 031	13, 379, 177	•
74. 00 07400 RENAL DIALYSIS	0. 231381	46, 965		0 0	10, 867	74.00
76. 00 03950 ANCI LLARY	0. 000000			0 0	0	76.00
76. 01 03610 SLEEP LAB	0. 000000			0 0	0	76.01
76. 03 03951 WOUND CARE	0. 259280			0 0	-	
OUTPATI ENT SERVICE COST CENTERS	0.237200	4, 330, 730	1	0 0	1, 174, 755	/0.03
90. 00 09000 CLINIC	0.00000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 093512			0 890		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245690			0 0	816, 697	
200.00 Subtotal (see instructions)		340, 610, 070		0 187, 921	35, 234, 764	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		340, 610, 070		0 187, 921	35, 234, 764	202.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 8/18/2020 12:	
		Title	× XVIII	Hospi tal	PPS	<u> </u>
	Cos	sts				
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				_
50. 00 05000 OPERATING ROOM	0	C				50.00
51. 00 05100 RECOVERY ROOM	0	-	1			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
54. 01 05401 ULTRASOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0					56.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	C	)			65.00
66. 00 06600 PHYSI CAL THERAPY	0	c				66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	28, 037				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 00 03950 ANCI LLARY	0	C				76.00
76.01 03610 SLEEP LAB	0	C				76.01
76.03 03951 WOUND CARE	0	0				76.03
OUTPATIENT SERVICE COST CENTERS	-	-	1			00.00
90. 00 09000 CLINIC	0					90.00
91.00 09100 EMERGENCY	0	83				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	28, 120				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	28, 120				202.00
202.00 Iner ondriges (The 200 - The 201)	0	1 20, 120	1			1202.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0035	Period: From 01/01/2019	Worksheet D Part II	
		Component	CCN: 15-T035	To 12/31/2019		
		Title	× XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,	Part I, col.		L. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 132, 779					
51.00 05100 RECOVERY ROOM	0	-	0.0000		-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	422, 001	16, 483, 028			0	
53.00 05300 ANESTHESI OLOGY	36, 262					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 507, 286	264, 510, 943				54.00
54.01 05401 ULTRASOUND	0	0	0.0000		0	
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58. 00 05800 MRI	0	0	0.0000		0	58.00
60. 00 06000 LABORATORY	639, 904					
65. 00 06500 RESPI RATORY THERAPY	113, 958					65.00
66. 00 06600 PHYSI CAL THERAPY	429, 420					
67.00 06700 OCCUPATI ONAL THERAPY	4, 618					•
68.00 06800 SPEECH PATHOLOGY	3, 493					•
69. 00 06900 ELECTROCARDI OLOGY	980, 924					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 616					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	298, 158					
73.00 07300 DRUGS CHARGED TO PATIENTS	361, 197					
74. 00 07400 RENAL DIALYSIS	22, 811	4, 324, 287			355	
76. 00 03950 ANCI LLARY	0	0	0.0000		0	
76.01 03610 SLEEP LAB	0	0	0.0000			
76. 03 03951 WOUND CARE	220, 631	11, 740, 219	0. 0187	93 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	-				
91. 00 09100 EMERGENCY	1, 480, 465	196, 543, 266			126	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 397, 757	0.0000	0 00	0	92.00
200.00 Total (lines 50 through 199)	8, 689, 523	1, 949, 715, 604	l	7, 142, 958	43, 703	200.00

Health Financial Systems	lealth Financial Systems PORTER MEMORIAL HOSPITAL In Lieu					
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0035	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T035	From 01/01/2019 To 12/31/2019		narodi
		component	CCN. 15-1055	10 12/31/2019	8/18/2020 12:	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description				ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	0.00	Adjustments	0.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS			1	0	0	50.00
	0	0		0 0	-	
51.00  05100 RECOVERY ROOM 52.00  05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0		54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0			0	58.00
60. 00 06000 LABORATORY	0	0			0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66,00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76. 00 03950 ANCI LLARY	0	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0	0		0 0	0	76.01
76.03 03951 WOUND CARE	0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00  Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-2552-									
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D			
THROUG	GH COSTS		Component		From 01/01/2019 To 12/31/2019		nored.		
			component	CCN: 15-T035	To 12/31/2019	Date/Time Pre 8/18/2020 12:	24 nm		
			Title	XVIII	Subprovider -	PPS	21 pm		
					I RF				
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost			
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,				
		Education Cost		Cost (sum of		(col. 5 ÷ col.			
			4)	col s. 2, 3,	8)	7)			
				and 4)		(see			
						instructions)			
		4.00	5.00	6.00	7.00	8.00			
	ANCI LLARY SERVICE COST CENTERS	-							
50.00	05000 OPERATING ROOM	0	0		0 383, 918, 687				
51.00	05100 RECOVERY ROOM	0	0		0 0	01000000	•		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 16, 483, 028		•		
53.00	05300 ANESTHESI OLOGY	0	0		0 20, 579, 329		•		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 264, 510, 943				
54.01	05401 ULTRASOUND	0	0		0 0	0. 000000			
56.00	05600 RADI OI SOTOPE	0	0		0 0	0. 000000			
57.00	05700 CT SCAN	0	0		0 0	0. 000000			
58.00	05800 MRI	0	0		0 0	0.000000			
60.00	06000 LABORATORY	0	0		0 237, 177, 107	0.000000	60.00		
65.00	06500 RESPI RATORY THERAPY	0	0		0 56, 502, 295				
66.00	06600 PHYSI CAL THERAPY	0	0		0 22, 946, 275		66.00		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 12, 338, 378		67.00		
68.00	06800 SPEECH PATHOLOGY	0	0		0 5, 007, 848	0. 000000	68.00		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 172, 572, 171	0.000000	69.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 42, 119, 546	0.000000	71.00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 194, 655, 208	0.000000	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 290, 899, 260	0.000000	73.00		
74.00	07400 RENAL DI ALYSI S	0	0		0 4, 324, 287	0. 000000	74.00		
76.00	03950 ANCI LLARY	0	0		o o	0. 000000	76.00		
76.01	03610 SLEEP LAB	0	0		o o	0. 000000	76.01		
76.03	03951 WOUND CARE	0	0		0 11, 740, 219	0. 000000	76.03		
	OUTPATIENT SERVICE COST CENTERS						1		
90.00	09000 CLINIC	0	0		0 0	0.000000	90.00		
91.00	09100 EMERGENCY	0	0		0 196, 543, 266	0. 000000	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 17, 397, 757		92.00		
200.00		0	0		0 1, 949, 715, 604		200.00		

APPORTIONNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-003 Component CCN: 15-1035         Period: From Outpatient To 12/31/2012         Worksheet D Part IV Date/Time Prepared: Subprovider -         Worksheet D Part IV Date/Time Prepared: Subprovider -                  Cost Center Description               Outpatient Ratio of Cost Cost, center Description               Outpatient Program	Health Financial Systems	PORTER MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Ancioan Goord         Component CCN: 15-T035         To         12/31/2019         Date/Time Preparad: BATE/Time Preparad: Component CCN: 15-T035         To         12/31/2019         Date/Time Preparad: BATE/Time Preparad: Cont of Cost Program Program Charges         Program Program Program Program Program Prosts (col. 6 ÷ col. 7)         Inpati ent Program Program Program Program Prosts (col. 6 ÷ col. 7)         Outpati ent Program Program Program Program Prosts (col. 6 ÷ col. 7)         Outpati ent Program Program Prosts (col. 6 ÷ col. 7)         Outpati ent Program Prosts (col. 9 ± col. 10)         Outpati ent Program Charges	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider CO	CN: 15-0035			
Cost Center Description         Outpatient Ratio of Cost (col. 6 + col. 7)         Inpatient Program Charges         Inpatient Program Charges         Outpatient Program Charges           50.00         05000         0PERATING ROOM         0.000000         91,709         0         0         0         0         0         0         50.00           50.00         05100         DELIVERY ROOM         0.000000         0         0         0         0         0         0         0         51.00           51.00         053.00         DELIVERY ROOM         0.000000         2,111         0         0         0         53.00         54.01           54.01         05401         ULTRASOUND         0.000000         0         0         0         0         0         0         56.00           58.00         05600 (MRI         0.0000000         1,331,575         0         0         0         0         <	THROUGH COSTS		Component	CON. 15 TO25			norod.
Cost Center Description         Outpatient To Charges (col. 6 + col. 7)         Inpatient Program (Charges (col. 6 + col. 7)         Inpatient Program (Charges (col. 6 + col. 7)         Outpatient Program (Charges (col. 2)         Outpatient Program (Charges (col. 2) <thoutpatient Program (Charges (col. 2)         Ou</thoutpatient 			component (	JUN: 15-1035	10 12/31/2019		
Cost Center Description         Outpatient Ratio of Cost (col. 6 + col. 7)         Inpatient Program Charges         Unpatient Program Pass-Through Costs (col. 8 x col. 10)         Outpatient Program Pass-Through Costs (col. 9 x col. 10)         Outpatient Program Pass-Through Costs (col. 9 x col. 10)         Outpatient Program Charges         Outpatient Program Charges <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Subprovider -</td> <td></td> <td></td>			Title	XVIII	Subprovider -		
Image: Program bit is the image of					I RF		
Image: transmission of the stand stan	Cost Center Description						
ANCI LLARY SERVICE COST CENTERS         Costs (col. 8 7)         Costs (col. 9 x col. 10)         Costs (col. 9 x col. 10)         Costs (col. 9 x col. 12)           50.00         D5000 0PERATING ROM         0.000000         91.00         11.00         12.00         13.00           50.00         D5000 0PERATING ROM         0.000000         91.709         0         0         0         51.00           50.00         D5100 RECOVERY ROM         0.000000         0         0         0         51.00           51.00         D5100 RECOVERY ROM         0.000000         0         0         0         51.00           52.00         D5100 RECOVERY ROM         LABOR ROM         0.000000         2,111         0         0         53.00           54.00         D5400 RADI 0LOGY-DI AGNOSTI C         0.000000         0         0         0         54.01           56.00         D5600 RADI 0LSTOPE         0.000000         0         0         0         55.00           58.00         D5800 RESPI RATORY         0.000000         1,131,575         0         0         66.00           66.00         D6000 RESPI RATORY THERAPY         0.000000         1,862,697         0         0         65.00           66.00         D6000 RESPI				9			
ANCI LLARY SERVICE COST CENTERS         x col. 10)         x col. 12)         x col. 12)           ANCI LLARY SERVICE COST CENTERS         0.000000         11.00         12.00         13.00           50.00         05000         0PERATI NG ROOM         0.000000         91,709         0         0         0         50.00           51.00         DS100 RECOVERY ROOM         0.000000         0         0         0         51.00           52.00         05200 DELI VERY ROOM & LABOR ROOM         0.000000         0         0         0         52.00           53.00         053000 RADI OLOGY - DI AGNOSTI C         0.000000         2, 111         0         0         53.00           54.01         DS400 RADI OLOGY- DI AGNOSTI C         0.000000         339, 997         0         6, 343         0         54.00           57.00         DS700 CT SCAN         0.000000         0         0         0         57.00           58.00         OS800 RAI         0.000000         1, 131, 575         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00 <td< td=""><td></td><td></td><td>Charges</td><td></td><td></td><td></td><td></td></td<>			Charges				
ANCI LLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           50.00         05000         OPERATI NG ROM         0.000000         91,709         0         0         0         50.00           51.00         05000         DELIVERY ROM         0.000000         0         0         0         51.00           52.00         05300         DELIVERY ROM & LABOR ROOM         0.000000         0         0         0         52.00           54.00         05300         ANESTHESI OLOGY         0.000000         2,111         0         0         0         54.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         0         0         0         0         0         54.00           56.00         05600         RADI OLSTOPE         0.000000         0         0         0         0         55.00           57.00         05700 CT SCAN         0.000000         0         0         0         56.00         56.00           66.00         066000         LABORATORY         0.000000         1,131,575         0         0         66.00         66.00           66.00         066000         PHOLOGY         <					8		
ANCILLARY SERVICE COST CENTERS         - <th< td=""><td></td><td></td><td>10.00</td><td></td><td>10.00</td><td></td><td></td></th<>			10.00		10.00		
50.00       05000       DPERATI NG ROOM       0.000000       91,709       0		9.00	10.00	11.00	12.00	13.00	
51.00       05100       RECOVERY ROOM       0.000000       0       0       0       0       0       0       0       51.00         52.00       05300       DELI VERY ROOM & LABOR ROOM       0.000000       0       0       0       52.00       0       0       0       0       52.00       0       0       0       53.00       53.00       53.00       0       53.00       0       53.00       0       53.00       0       53.00       0       53.00       0       53.00       0       53.00       0       54.01       0       54.01       0       54.01       0       6.343       0       54.00       56.00       0       0       0       0       0       56.00       56.00       57.00       0       0       0       0       57.00       57.00       0       0       0       0       57.00       50.00       0       0       0       0       57.00       50.00       <		0.000000	01 700		0	0	50.00
52.00       05200       DELIVERY ROM & LABOR ROOM       0.000000       0       0       0       52.00         53.00       05300       ANESTHESI OLOGY       0.000000       2,111       0       0       53.00         54.00       54.00       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       0       54.00         54.01       05401       ULTRASOUND       0.000000       0       0       0       54.00         56.00       05600       RADI OLSOTPE       0.000000       0       0       0       55.00         57.00       05700 CT SCAN       0.000000       0       0       0       58.00         66.00       06500 RESPI RATORY THERAPY       0.000000       1,131,575       0       0       66.00         66.00       06600 PHYSI CAL THERAPY       0.000000       1,862,697       0       0       67.00         67.00       0CUPATI ONAL THERAPY       0.000000       1,862,697       0       0       67.00         69.00       06700 ELECTROCARDI OLOGY       0.000000       1,862,697       0       0       67.00         71.00       MDI OLAL THERAPY       0.000000       1,862,697       0       0       67.00 <t< td=""><td></td><td></td><td>91, 709</td><td></td><td>0</td><td>-</td><td></td></t<>			91, 709		0	-	
53.00       05300       ANESTHESI OLOGY       0.000000       2,111       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       339,997       0       6,343       0       54.00         54.01       05400       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       0       54.00         56.00       05600       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       0       56.00         57.00       05500       CT SCAN       0.000000       0       0       0       57.00         58.00       06000       LABORATORY       0.000000       0       0       0       68.00         60.00       06000       LABORATORY       0.000000       1, 832       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       1, 832       0       0       67.00       68.00         68.00       06600       PHYSI CAL THERAPY       0.000000       1, 832       0       0       67.00       69.00       67.00       67.00       68.00       69.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00			0		0 0	-	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       339,997       0       6,343       0       54.00         54.01       05401       UTRASOUND       0.000000       0       0       0       54.01         57.00       05700       CT SCAN       0.000000       0       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       0       58.00         60.00       06000       LABORATORY       0.000000       1,131,575       0       0       66.00       65.00         65.00       06500       RESPI RATORY THERAPY       0.000000       1,852,697       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       1,961,114       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       464,210       0       0       68.00         71.00       MDIO MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       77.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00			0		0 0	-	
54.01       05401       ULTRASOUND       0.00000       0       0       0       0       0       54.01         56.00       05600       RADI 0I SOTOPE       0.000000       0       0       0       56.00         57.00       057.00       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       58.00         60.00       06000       LABORATORY       0.000000       1, 131, 575       0       0       66.00         65.00       06500       RESPI RATORY THERAPY       0.000000       1, 832       0       0       66.00         67.00       06000       DCUPATI ONAL THERAPY       0.000000       1, 862, 697       0       0       66.00         67.00       06000       DCUPATI ONAL THERAPY       0.000000       1, 961, 114       0       0       68.00         68.00       06800       SPECH PATHOLOGY       0.000000       67, 503       0       239       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       12, 509       0       0       72.00         74.00       RENAL					0 0		
56.00       05600       RADI 0I SOTOPE       0.000000       0       0       0       56.00         57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       58.00         60.00       06000       LABORATORY       0.000000       1,131,575       0       0       66.00         65.00       06500       RESPI RATORY THERAPY       0.000000       1,832       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0.000000       1,862,697       0       0       66.00         67.00       06200       DEECH PATHOLOGY       0.000000       1,961,114       0       0       68.00         68.00       06900       ELECTROCARDI OLOGY       0.000000       67.503       0       239       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       1,122,905       0       12,969       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       67,320       0       0       74.00         74.00       7400       0			339, 997				
57. 00       05700       CT SCAN       0.000000       0       0       0       57. 00         58. 00       05800       MRI       0.000000       0       0       0       58. 00         60. 00       06000       LABORATORY       0.000000       1, 131, 575       0       0       60. 00         65. 00       06500       RESPI RATORY THERAPY       0.000000       1, 832       0       0       65. 00         66. 00       06000       CUPATI ONAL THERAPY       0.000000       1, 862, 697       0       0       66. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0.000000       1, 961, 114       0       0       68. 00         69. 00       07100       MEDI CAL SUPLI ES CHARGED TO PATI ENT       0.000000       67. 503       0       239       0       69. 00         71. 00       07100       MEDI CAL SUPLI ES CHARGED TO PATI ENTS       0.000000       790       0       0       71. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       67. 320       0       0       72. 00         74. 00       74. 00       74. 00       0.000000       0       0       0       76. 01         76. 01 <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>Ű</td> <td></td>			0		0 0	Ű	
58.00       05800       MRI       0.00000       0			0		0 0	Ű	
60.00       LABORATORY       0.000000       1, 131, 575       0       0       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       1, 832       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       1, 862, 697       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       1, 64, 210       0       0       68.00         68.00       SPECH PATHOLOGY       0.000000       464, 210       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       67.503       0       239       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       790       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       1, 122, 905       0       12, 969       0       72.00         74.00       ORGS CHARGED TO PATI ENTS       0.000000       67, 320       0       0       74.00       74.00       74.00       74.00       74.00       74.00       76.01       76.01       76.01       76.01       76.01       76.01			0		0 0		
65.00       06500       RESPI RATORY THERAPY       0.000000       1,832       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       1,862,697       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       1,961,114       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       464,210       0       0       0       68.00         69.00       ELECTROCARDI OLOGY       0.000000       67,503       0       239       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       790       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       1,122,905       0       12,969       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       67,320       0       0       74.00         76.01       03610       SLEP LAB       0.000000       0       0       0       0       76.01         76.02       09000       CLI NI C       0.000000       0       0       0 <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0		0 0		
66.00       06600       PHYSI CAL THERAPY       0.00000       1,862,697       0       0       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       1,961,114       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       464,210       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       67,503       0       239       0       69.00         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       790       0       0       71.00         72.00       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       12,509       0       0       72.00         73.00       07400       RENAL DI ALYSI S       0.000000       1,122,905       0       12,969       73.00         74.00       0350       ANCI LLARY       0.000000       67,320       0       0       74.00         76.01       03610       SLEP LAB       0.000000       0       0       0       0       76.01         76.02       03950       ANCI LLARY       0.000000       0       0       0       0       76.01         76.03					0 0	-	
67.00       06700       0CCUPATIONAL THERAPY       0.00000       1,961,114       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       464,210       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       67,503       0       239       0       69.00         71.00       MEDICAL SUPPLIES CHARGED TO PATIENT       0.000000       790       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       12,509       0       0       72.00         73.00       07400       RENAL DI ALYSIS       0.000000       12,2905       0       12,969       0       73.00         74.00       03950       ANCI LLARY       0.000000       67,320       0       0       74.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       0       76.01         76.01       03610       SLEEP LAB       0.000000       0       0       0       0       76.01         76.02       09000       CLINIC       0.000000       0       0       0       0       0					0 0	Ű	
68.00       06800       SPEECH PATHOLOGY       0.00000       464, 210       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       67, 503       0       239       0       69.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       790       0       0       0       71.00         72.00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       12,509       0       0       72.00         73.00       O7300       DRUGS CHARGED TO PATI ENTS       0.000000       1,122,905       12,969       0       73.00         74.00       O7400       RENAL DI ALYSI S       0.000000       67,320       0       0       74.00         76.00       03950       ANCI LLARY       0.000000       0       0       0       74.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       0       76.00         76.03       03951       WOUND CARE       0.000000       0       0       0       0       76.01         76.03       03951       WOUND CARE       0.000000       0       0       0       0       0       76.03					0 0	Ű	
69.00         06900         ELECTROCARDIOLOGY         0.000000         67,503         0         239         0         69.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0.000000         790         0         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         12,509         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         1,122,905         0         12,669         0         73.00           74.00         07400         RENAL DI ALYSIS         0.000000         67,320         0         0         0         74.00           76.00         03950         ANCI LLARY         0.000000         0         0         0         76.00         76.00           76.01         03610         SLEEP LAB         0.000000         0         0         0         0         76.01           76.03         03951         WOUND CARE         0.000000         0         0         0         76.01           76.04         03951         WOUND CARE         0.000000         0         0         0         0         0					0 0	-	
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         0.00000         790         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0.000000         12,509         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         12,509         0         12,969         0         73.00           74.00         07400         RENAL DI ALYSI S         0.000000         67,320         0         0         0         74.00           76.00         03950         ANCI LLARY         0.000000         0         0         0         76.00           76.01         03610         SLEEP LAB         0.000000         0         0         0         76.01           76.03         03951         WOUND CARE         0.000000         0         0         0         76.01           76.01         03610         SLEEP LAB         0.000000         0         0         0         0         76.01           76.02         03951         WOUND CARE         0.000000         0         0         0         0         0         0         0         0         0         0					0		
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0.000000         12,509         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         1,122,905         0         12,969         0         73.00           74.00         07400         RENAL DI ALYSI S         0.000000         67,320         0         0         0         74.00           76.00         03950         ANCI LLARY         0.000000         0         0         0         76.00           76.01         03610         SLEEP LAB         0.000000         0         0         0         76.01           76.02         03951         WOUND CARE         0.000000         0         0         0         76.01           76.03         03951         WOUND CARE         0.000000         0         0         0         0         76.01           76.02         09000         CLI NI C         0.000000         0         0         0         0         0         0           90.00         09100         EMERGENCY         0.000000         16,686         0         445         0         91.00           92.00 <t< td=""><td></td><td></td><td></td><td></td><td>0 239</td><td></td><td></td></t<>					0 239		
73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       1,122,905       0       12,969       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       67,320       0       0       0       74.00         76.00       03950       ANCI LLARY       0.000000       0       0       0       0       76.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       0       76.01         76.02       03951       WOUND CARE       0.000000       0       0       0       0       76.01         76.01       03951       WOUND CARE       0.000000       0       0       0       0       76.01         76.02       00707       CLINIC       0.000000       0       0       0       0       76.01         76.01       07900       CLINIC       0.000000       0       0       0       0       76.01         77.02       09000       EMERGENCY       0.000000       0       0       0       90.00       91.00         91.00       09100       EMERGENCY       0.000000       16,686       0       445       0       91.00					0 0	-	
74.00         07400         RENAL DI ALYSI S         0.00000         67,320         0         0         74.00           76.00         03950         ANCI LLARY         0.000000         0         0         0         76.00           76.01         03610         SLEEP LAB         0.000000         0         0         0         0         76.01           76.02         03951         WOUND CARE         0.000000         0         0         0         0         76.01           76.03         03951         WOUND CARE         0.000000         0         0         0         0         76.03           00000         CLINIC         0.000000         0					0 0	-	
76.00         03950         ANCI LLARY         0.00000         0         0         0         0         76.00           76.01         03610         SLEEP LAB         0.00000         0         0         0         0         76.01           76.02         03951         WOUND CARE         0.00000         0         0         0         0         76.01           0.3951         WOUND CARE         0.00000         0         0         0         0         76.03           0UTPATI ENT SERVICE COST CENTERS         0.00000         0         0         0         0         90.00         91.00         92.00         92.00         0         0         0         0         91.00         92.00         92.00         0         0         0         92.00         0         0         92.00         92.00         0         0         0         92.00         92.00							
76. 01         03610         SLEEP LAB         0.00000         0         0         0         0         76. 01           76. 03         03951         WOUND CARE         0.00000         0         0         0         0         76. 01           76. 01         03951         WOUND CARE         0.00000         0         0         0         76. 01           00 0000         CLI NI C         0.00000         0         0         0         0         90. 00           90. 00         09000         CLI NI C         0.000000         0         0         0         90. 00         91. 00         91. 00         91. 00         91. 00         92. 00         058ERVATI ON BEDS (NON-DI STI NCT PART         0.000000         0         0         0         0         92. 00			67, 320		0 0	-	
76. 03         03951         WOUND CARE         0.00000         0         0         0         0         76. 03           OUTPATIENT SERVICE COST CENTERS         0.00000         0         0         0         0         90. 00           90. 00         09000         CLINIC         0.000000         0         0         0         90. 00           91. 00         09100         EMERGENCY         0.000000         16, 686         0         445         0         91. 00           92. 00         0BSERVATION BEDS (NON-DI STINCT PART         0.000000         0         0         0         92. 00			0		0 0	-	
OUTPATI ENT SERVICE COST CENTERS           90. 00         09000 CLI NI C         0.000000         0         0         0         90. 00           91. 00         09100         EMERGENCY         0.000000         16, 686         0         445         0         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         0.000000         0         0         0         0         92. 00			0		-	0	
90.00         09000         CLINIC         0.00000         0         0         0         90.00           91.00         09100         EMERGENCY         0.000000         16,686         0         445         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.000000         0         0         0         0         92.00		0.000000	0		0 0	0	76.03
91. 00         09100         EMERGENCY         0. 000000         16, 686         0         445         0         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0. 000000         0         0         0         0         92. 00		0,000000			0	0	00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 000000 0 0 0 0 92. 00			-			-	
			16, 686				
200. 00    10 tai (111es ou tilioùgn 199)     1, 142, 958  0  19, 996  0 200. 00		0.000000	7 142 050		-	-	
	200.00   Total (Thes 50 through 199)		7, 142, 958	l	U 19, 996		200.00

Health Financial Systems	PORTER MEMORIA	AL_HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0035	Peri od:	Worksheet D	
		Company	20N 15 T025	From 01/01/2019	Part V	
		Component (	CCN: 15-T035	To 12/31/2019	Date/Time Pre 8/18/2020 12:	pared: 24 nm
		Title	XVIII	Subprovider -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	ŕ	Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 072586	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 315165	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 011921	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.070612	6, 343		0 0	448	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0.075209	0		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 070297	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 203648	0			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 103351	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 202083	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 071733	239		0 0	17	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 071733	239		0 0	0	71.00
		0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 135635	•		0 2,209	-	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 149905	12, 969			1, 944	73.00
74.00 07400 RENAL DI ALYSI S	0. 231381	0		0 0	0	74.00
76. 00 03950 ANCI LLARY	0. 000000	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0. 000000	0		0 0	0	76.01
76. 03 03951 WOUND CARE	0. 259280	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 093512	445		0 0	42	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245690	0		0 0	0	92.00
200.00 Subtotal (see instructions)		19, 996		0 2, 209	2, 451	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		40			a ··	
202.00  Net Charges (line 200 - line 201)		19, 996		0 2, 209	2, 451	202.00

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	u of Form CMS-255	52-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0035 CCN: 15-T035	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepar 8/18/2020 12:24	red:
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	sts Cost	-			
Cost center bescription	Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0			5	50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0			5	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			5	54.00
54. 01 05401 ULTRASOUND	0	0			5	54.01
56. 00 05600 RADI OI SOTOPE	0	0			5	56.00
57.00 05700 CT SCAN	0	0			5	57.00
58. 00 05800 MRI	0	0			5	58.00
60. 00 06000 LABORATORY	0	0			6	50.00
65. 00 06500 RESPI RATORY THERAPY	0	0			6	55.00
66. 00 06600 PHYSI CAL THERAPY	0	0			6	56.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			6	57.00
68.00 06800 SPEECH PATHOLOGY	0	0			6	58.00
69. 00 06900 ELECTROCARDI OLOGY	0	0			6	59.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			7	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	331			7	73.00
74.00 07400 RENAL DIALYSIS	0	0			7	74.00
76. 00 03950 ANCI LLARY	0	0			7	76.00
76.01 03610 SLEEP LAB	0	0			7	76. 01
76. 03 03951 WOUND CARE OUTPATI ENT SERVICE COST CENTERS	0	0			7	76. 03
90. 00 09000 CLINIC	0	0			0	90.00
90. 00 109000 CET NTC 91. 00 09100 EMERGENCY	0					90.00 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				71.00 72.00
200.00 Subtotal (see instructions)		331				92.00 00.00
201.00 Less PBP Clinic Lab. Services-Program	0	331				0.00
Only Charges	0				20	<i>.</i>
202.00 Net Charges (line 200 - line 201)	0	331			20	02.00

Anci LLARY SERVICE Cost Center Description         Cost to Charge Ratio From Worksheet C, Part I, col. 9         PS Reimbursed Services (see Inst.)         Cost Cost Reimbursed Services (see Inst.)         Cost Cost Services (see Inst.)         Cost Reimbursed Services (see Inst.)         Cost Reimbursed Services (see Inst.)         Cost Services (sevices (sevice (sevices (sevices (sevice (se	Health Financial Systems	PORTER MEMORI				u of Form CMS-	2552-10	
Cost Center Description         Cost to Charges         Cost cost cost (csc cost cost cost cost cost cost cost c	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider C		From 01/01/2019	Date/Time Pre	pared: 24 pm	
Cost Center Description         Cost to Charge PFS Reinbursed Worksheet C, Part I, col. 9         Cost inst. ) Services (see inst. )         Cost Reinbursed Services (see inst. )         Cost Reinbursed Services (see inst. )         PFS Services (see inst. )           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (PERATING ROOM         0.072586         0         0         20,803,947         0         50.00           50.00         05000 (PERATING ROOM         0.072586         0         0         7,614         52.00           50.00         05000 (RD RDI COVERY ROOM & LABOR ROOM         0.315165         0         7,614         52.00           51.00         051.00 (RD COVERY ROOM & LABOR ROOM         0.011921         0         0         1.132,032         0         53.00           54.00 (SA00 RAD IO SOTOPE         0.0000000         0         0         0         0         57.00         54.00           55.00 (SR0 COVERY ROM         0.0000000         0         0         0         0         57.00         54.00         56.00         57.00         54.00         56.00         56.00         57.00         56.00         56.00         57.00         56.00         56.00         57.00         57.00			Titl	e XIX	Hospi tal			
ANCI LLARY SERVICE COST CENTERS         Services (see inst.)         Relinbursed inst.)         Relinbursed inst.)         Relinbursed Subject To Ded. & Colins.         (see inst.)				Charges		Costs		
Worksheet C, Part I, col. 9         inst.)         Services Subject To Ded. & Coins. (see inst.)         Services Subject To Ded. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 0PERATING ROOM         0.072586         0         0         2.803,947         0         50.00           51.00         05100 RECOVERY ROOM         0.072586         0         0         2.803,947         0         50.00           52.00         05200 DELIVERY ROOM         0.1315165         0         0         7.614         0.52.00         53.00         54.00         0.54.01         0.40000         0         0         54.00         54.00         0.070612         0         0         1.132,032         0.53.00         54.00         56.00         0         0         0         54.00         56.00         0         0         0         54.00         56.00         66.00         0         0         0         54.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         57.00         57.00         57.00         57.00	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services		
ANCILLARY SERVICE COST CENTERS         Subject To         Subject To           1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         0         0         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         0.072586         0         0         7.614         0.50.0           52.00         05200 DELIVERY ROOM         0.000000         0         1.12,23.2         0.53.0           53.00         05300 ANESTHESIOLOGY         0.017921         0         1.1,2,03.2         0.53.0           54.00         05400 RADIOLOCY-DIAGNOSTIC         0.070612         0         21,027,875         0.54.0           56.00         05600 RDI ULTRASOUND         0.000000         0         0         0.58.0           66.00         06000 RESPI RATORY THERAPY         0.075209         0         14,636,487         0.60.0           66.00         06000 RESPI RATORY THERAPY         0.075209         0         14,636,487         0.67.00           66.00         06000 RESPI RATORY THERAPY         0.03263         0         669.0         669.0           66.00         06000 RESPI RATORY THERAPY         0.035209         0         14,636,487         6			Services (see		Reimbursed	(see inst.)		
Image: Note of the instruction of the instructi		Worksheet C,	inst.)	Servi ces	Services Not			
ANCILLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         (see inst.)           ANCILLARY SERVICE COST CENTERS         0         3.00         4.00         5.00           S0.00         05000 (PERATI NG ROOM         0.072586         0         0         0.00000           52.00         05200 (DI RECOVERY ROOM         0.000000         0         0         0         51.00           53.00         05300 (APESTHESI OLOCY         0.011921         0         1.132.032         053.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.070612         0         0         0         54.00           56.00         05500 RADI OISTOPE         0.000000         0         0         0         55.00           66.00         0500 NRI         0.000000         0         0         0         55.00           66.00         06000 LABORATORY         0.075209         0         14.636.487         66.00           66.00         06000 PHYSI CAL THERAPY         0.07297         0         511.447         65.00           66.00         06000 PHYSI CAL THERAPY         0.103351         0         195.931         67.00           67.00         06700 OCUPATI ONAL THERAPY         0.103351         0		Part I, col. 9		Subject To	Subject To			
Image: Note LLARY SERVICE COST CENTERS         Image: Note LLARY SERVICE COST CENTERS           50.00         05000 (PERATI NG ROOM         0.072586         0         0         20,803,947         0         50.00           51.00         05000 (PERATI NG ROOM         0.000000         0         0         0         51.00           52.00         05200 (DELIVERY ROOM & LABOR ROOM         0.315165         0         0         7,614         0.52.00           54.00         05400 (RADI OLOGY - DI AGNOSTI C         0.070612         0         1.32,032         0.53.00           54.01         05401 (ULTRASOUND         0.000000         0         0         0         54.00           55.00         05600 RADI OLOGY - DI AGNOSTI C         0.000000         0         0         0         54.00           56.00         05600 RADI OLOGY - DI AGNOSTI C         0.000000         0         0         0         54.00           57.00         05700 CT SCAN         0.000000         0         0         0         56.00           58.00         08800 RRSI RATORY         0.075209         0         14,636,487         66.00           66.00         06600 PHYSI CAL THERAPY         0.203648         0         1.007,227         66.00				Ded. & Coi ns.	Ded. & Coins.			
INCLILLARY SERVICE COST CENTERS         Image: Cost Centers           50.00         05000 OPERATI NG R00M         0.072586         0         0.0700         0				(see inst.)	(see inst.)			
50.00       OPERATING ROOM       0.072586       0       0       20.803,947       0       50.00         51.00       05100 RECOVERY ROOM       0.000000       0       0       0       51.00         52.00       05200 DELIVERY ROOM & LABOR ROOM       0.315165       0       0       7,614       0       52.00         53.00       05300 ANESTHESI OLOGY       0.011921       0       0       1,132,032       0       53.00         54.00       05400 RADI OLGOY-DI AGNOSTI C       0.070612       0       0       0       0       54.00         55.00       05401       ULTRASOUND       0.000000       0       0       0       54.00         56.00       05600 RADI OLSOTPE       0.000000       0       0       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       58.00       0       0       0       0       57.00       0       51.1447       0       65.00       06500       RESPI RATORY THERAPY       0.075209       0       14,636,487       0       60.00       66.00       66.00       67.00       0       15.01,398       67.00       67.00       67.00       0.0700       0.073731		1.00	2.00	3.00	4.00	5.00		
51.00       05100       RECOVERY ROOM       0.000000       0       0       0       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.315165       0       0       7,614       0       53.00         53.00       05300       ANESTHESI OLOGY       0.011921       0       0       1,312,032       0       54.00         54.00       05400       RADI OLOGY-JI AGNOSTI C       0.070612       0       0       21,027,875       0       54.01         56.00       05600       RADI OLSTOPE       0.000000       0       0       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       0       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00	ANCI LLARY SERVI CE COST CENTERS							
52.00       05200       DELIVERY ROM & LABOR ROM       0.315165       0       7,614       0       52.00         53.00       05300       ANESTHESI OLOGY       0.011921       0       1,132.032       53.00         54.00       05400       RADI LOGY-DI AGNOSTI C       0.070612       0       21.027.875       54.00         54.00       05401       UTRASOUND       0.000000       0       0       56.00         54.00       05600       RADI OI SOTOPE       0.000000       0       0       56.00         57.00       05700 CT SCAN       0.000000       0       0       57.00       05800 MRI       0.000000       0       0       58.00         60.00       06500       RESPI RATORY THERAPY       0.07297       0       14.636.487       66.00         61.00       066000       LABRATIONAY       0.23648       0       1,007.227       66.00         62.00       066000       PHYSI CAL THERAPY       0.23648       0       1,549.601       77.00         63.00       066000       DECTROCARDI IONAL THERAPY       0.202083       0       669.00       77.61.398       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.13555	50.00 05000 OPERATING ROOM	0. 072586	0	)	0 20, 803, 947	0	50.00	
53:00       05300       ANESTHESI OLOGY       0.011921       0       0       1,132,032       0       53.00         54:00       05400       RADI OLOGY-DI AGNOSTI C       0.070612       0       0       21,027,875       0       54.01         54:01       0LTRASOUND       0.000000       0       0       0       54.01       0       55.00       0       56.00       0       0       0       54.01       0       56.00       0       0       0       0       54.01       0       56.00       0       0       0       56.00       56.00       0       0       0       0       56.00       0       0       0       0       57.00       0       0       0       0       58.00       0       05800       NRI N       0.000000       0       0       0       58.00       0       0500       RESPI RATORY THERAPY       0.070297       0       0       14.436.487       66.00       66.00       0       0.077.33       0       0       1.007,227       66.00       66.00       66.00       0       0.0071733       0       0       7.561,398       66.00       69.00       69.00       0       0.00000       0       0       7.200 <td>51.00 05100 RECOVERY ROOM</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>51.00</td>	51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.070612       0       21,027,875       0       54.00         54.01       05401       ULTRASOUND       0.000000       0       0       0       54.00         54.01       05401       ULTRASOUND       0.000000       0       0       0       54.00         55.00       05500       RATI OLOGY-DI AGNOSTI C       0.000000       0       0       0       56.00         57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.0075209       0       14,453,487       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.07297       0       14,453,487       66.00         66.00       06600       PHYSI CAL THERAPY       0.202083       0       1007,227       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.202083       0       75.51.388       69.00         69.00       06900       ELECTROCARDI OLOGY       0.21355       0       1,549,601       71.00         71.00       07200       IMPL L       DEV. CHARGED TO PATI ENT       0.87055       0       1,4669,73	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 315165	0		0 7,614	0	52.00	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.070612       0       21,027,875       0       54.00         54.01       05401       ULTRASOUND       0.000000       0       0       0       54.00         54.01       05500       RADI OLOGY-DI AGNOSTI C       0.000000       0       0       0       54.00         54.00       05500       RATI OLSTOPE       0.000000       0       0       0       55.00         55.00       05800       RATI OLSTOPE       0.000000       0       0       0       57.00         56.00       05800       RATI OLSTOPE       0.000000       0       0       0       58.00       56.00	53. 00 05300 ANESTHESI OLOGY	0. 011921	0		0 1, 132, 032	0	53.00	
54.01       05401       ULTRASOUND       0.000000       0       0       0       0       54.00         56.00       05600       RADI 01 SOTOPE       0.000000       0       0       0       55.00       0       55.00       0       50.00       0       0       0       0       55.00       0       50.00       0       0       0       0       0       0       55.00       0       50.00       0       0       0       0       0       0       57.00       0       54.01       0       0       0       0       0       0       57.00       0       0       0       0       0       0       0       0       0       0       57.00       0       0       14.636.487       0       0       0       55.00       0.500       RESPI RATCRY THERAPY       0.075209       0       0       11.477       0       65.00       0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.070612	0				54.00	
56.00       05600       RADI 0I SOTOPE       0.000000       0       0       0       56.00         57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       57.00         66.00       06000       LABORATORY       0.075209       0       14,636,487       06.00         65.00       06500       RESPI RATORY THERAPY       0.070297       0       0       511,447       0       65.00         66.00       06000       LABORATORY       0.073207       0       0       195,931       0       67.00         06700       0CCUPATI ONAL THERAPY       0.103351       0       1,007,227       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.202083       0       7,561,398       0       90.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.087055       0       1,549,601       0       71.00         72.00       07300       INPL. DEV. CHARGED TO PATI ENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       INPL.					0 0		54.01	
57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       58.00         60.00       LABORATORY       0.075209       0       14,636,487       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.075209       0       14,636,487       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.070297       0       0       195,931       0       67.00         66.00       06600       PECH PATHOLOGY       0.202648       0       1,007,227       0       68.00         68.00       06800       SPECH PATHOLOGY       0.202083       0       0       669,097       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.071733       0       7,561,398       0       69.00         71.00       07100       IMPL. DEV. CHARGED TO PATI ENTS       0.13565       0       0       2,917,621       0       72.00       72.00       72.00       72.00       0       0.2917,621       0       72.00       72.00       73.00       074.00       0       0       0					0 0			
58.00       05800       MRI       0.000000       0       0       0       58.00         60.00       06000       LABORATORY       0.075209       0       0       14,636,487       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.070297       0       0       11,447       0       65.00         66.00       06000       PLYSI CAL THERAPY       0.203648       0       1,007,227       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.103351       0       195,931       0       67.00         68.00       SPEECH PATHOLOGY       0.202083       0       0       669,697       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.071733       0       7.561,398       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.087055       0       1,549,601       71.00       72.00       73.00       0       73.00       73.00       0       73.00       73.00       0       74.00       0       74.00       0       0       74.00       0       74.00       0       74.00       0       76.00       0       0       76.00<					0 0			
60.00       LABORATORY       0.075209       0       14,636,487       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.070297       0       0       511,447       0       65.00         66.00       PHYSI CAL THERAPY       0.203648       0       1,007,227       0       66.00         70.00       06700       0CCUPATI ONAL THERAPY       0.103351       0       195,931       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.202083       0       0       669,697       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.071733       0       0       7,561,398       0       90.00         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.87055       0       1,549,601       0       71.00       71.00       73.00       07300       DRUGS CHARGED TO PATI ENTS       0.135635       0       2,917,621       0       72.00       73.00       74.00       74.00       0       0       0       0       73.00       73.00       74.00       0       0       0       0       74.00       74.00       74.00       74.00       76.00       0       0       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>						-		
65.00       06500       RESPI RATORY THERAPY       0.070297       0       0       511,447       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.203648       0       0       1,007,227       0       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.103351       0       0       195,931       0       67.00         68.00       SPEECH PATHOLOGY       0.202083       0       0       669,697       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.0171733       0       0       7,561,398       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.087055       0       0       1,549,601       0       71.00         72.00       07200       INPL.       DEV. CHARGED TO PATI ENTS       0.135635       0       0       2,917,621       0       73.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       0       0       74.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.0					0 1/ 636 /87			
66.00       06600       PHYSI CAL THERAPY       0.203648       0       0       1,007,227       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.103351       0       0       195,931       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.202083       0       0       669.00       669.00       669.00       7,561,398       0       69.00         69.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.0071733       0       0       1,549,601       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0.149905       0       0       0       74.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       74.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00         76.02       09900       CLI NI C       0.0000000								
67.00       06700       0CCUPATI ONAL THERAPY       0.103351       0       0       195,931       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.202083       0       0       669,697       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.071733       0       0       7,551,398       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.087055       0       0       2,917,621       0       72.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.135635       0       0       14,669,733       0       74.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       0       74.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00       76.00         70.00       03951       WOND CARE       0.259280       0       0       1,090,046       76.00         76.03       03951       00       0			0					
68.00       06800       SPEECH PATHOLOGY       0.202083       0       0       669,697       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.071733       0       0       7,561,398       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.087055       0       0       1,549,601       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.135635       0       0       2,917,621       0       72.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       74.00       0       0       0       74.00       76.00       76.00       76.00       0       0       74.00       0       0       0       0       74.00       76			0					
69.00       06900       ELECTROCARDIOLOGY       0.071733       0       7,561,398       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.087055       0       1,549,601       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.149905       0       0       14,669,733       0       74.00         74.00       07400       RENAL DIALYSIS       0.231381       0       0       0       74.00         76.00       03950       ANCILLARY       0.000000       0       0       0       74.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00         76.03       03951       WOUND CARE       0.259280       0       0       1,090,046       76.00         90.00       09000       CLINIC       0.000000       0       0       0       90.00         91.00       09100       EMERGENCY       0.093512       0       0       1,457,847       92.00         920.00       09200       DSERVATI ON			0					
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.087055       0       1,549,601       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.135635       0       0       14,669,733       0       73.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       0       74.00         76.00       03950       ANCI LLARY       0.000000       0       0       0       76.00       76.00         76.101       03610       SLEEP LAB       0.000000       0       0       0       76.00         76.01       03951       WOUND CARE       0.259280       0       0       1,090,046       0       76.00         70.00       09000       CLI NI C       0.000000       0       0       0       90.00						-		
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.135635       0       0       2,917,621       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.149905       0       0       14,669,733       0       73.00         74.00       07400       RENAL DI ALYSIS       0.231381       0       0       0       0       74.00         76.00       03950       ANCI LLARY       0.000000       0       0       0       76.00       76.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00       76.00         76.03       03951       WOUND CARE       0.000000       0       0       0       76.00       76.00         76.03       03951       WOUND CARE       0.000000       0       0       0       76.00       76.00         70.00       09000       CLINIC       0.000000       0       0       90.00       9							1	
73.00       07300       DRUGS CHARGED TO PATIENTS       0.149905       0       14,669,733       0       73.00         74.00       07400       RENAL DI ALYSI S       0.231381       0       0       0       0       74.00         76.00       03950       ANCI LLARY       0.000000       0       0       0       76.00         76.01       03610       SLEEP LAB       0.000000       0       0       0       76.00         76.03       03951       WOUND CARE       0.259280       0       0       1,090,046       76.00         76.03       09000       CLINIC       0.000000       0       0       90.00						-		
74. 00       07400       RENAL DI ALYSI S       0. 231381       0       0       0       0       74. 00         76. 00       03950       ANCI LLARY       0. 000000       0       0       0       0       76. 00         76. 01       03610       SLEEP LAB       0. 000000       0       0       0       0       76. 00         76. 03       03951       WOUND CARE       0. 000000       0       0       0       76. 00         00176. 03       03951       WOUND CARE       0. 259280       0       0       1, 090, 046       0       76. 00         00179ATH ENT SERVICE COST CENTERS       0. 000000       0       0       0       0       90. 00         90. 00       09100       EMERGENCY       0. 000000       0       0       90. 00         91. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0. 245690       0       1, 457, 847       0       92. 00         920. 00       Subtotal (see instructions)       0       0       0       125, 693, 846       0       200. 00         201. 00       Less PBP Clinic Lab. Services-Program       0       0       0       201. 00       201. 00       201. 00       0       201. 0								
76.00         03950         ANCI LLARY         0.000000         0         0         0         76.00 <th 70.<="" td=""><td></td><td></td><td>0</td><td></td><td>0 14,669,733</td><td></td><td></td></th>	<td></td> <td></td> <td>0</td> <td></td> <td>0 14,669,733</td> <td></td> <td></td>			0		0 14,669,733		
76. 01         03610         SLEEP LAB         0.000000         0         0         0         76. 01         76. 01         03951         WOUND CARE         0.000000         0         0         0         76. 01         76. 01         76. 01         03951         WOUND CARE         0.0259280         0         0         0         76. 01			0		0 0	-		
76. 03         03951         WOUND CARE         0. 259280         0         0         1, 090, 046         0         76. 03           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         90. 00					0 0			
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0.000000         0         0         0         90.00           91.00         09100         EMERGENCY         0.093512         0         0         36,455,343         0         91.00           92.00         09200         DBSERVATI ON BEDS (NON-DI STINCT PART         0.245690         0         0         1,457,847         0         92.00           200.00         Subtotal (see instructions)         0         0         125,693,846         0         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00         201.00								
90. 00         09000         CLINIC         0.000000         0         0         0         0         90. 00           91. 00         09100         EMERGENCY         0.093512         0         0         36, 455, 343         0         91. 00           92. 00         09200         DBSERVATION BEDS (NON-DISTINCT PART         0.245690         0         0         1, 457, 847         0         92. 00           200. 00         Subtotal (see instructions)         0         0         125, 693, 846         0         200. 00           201. 00         Less PBP Clinic Lab. Services-Program         0         0         0         201. 00		0. 259280	0		0 1, 090, 046	0	76.03	
91.00         09100         EMERGENCY         0.093512         0         36,455,343         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.245690         0         1,457,847         0         92.00           200.00         Subtotal (see instructions)         0         0         125,693,846         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         0         0         201.00         0			-			-		
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0. 245690         0         1, 457, 847         0         92. 00           200. 00         Subtotal (see instructions)         0         0         125, 693, 846         0         200. 00           201. 00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         0         201. 00				1				
200.00         Subtotal (see instructions)         0         0         125, 693, 846         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201.00								
201.00     Less PBP Clinic Lab. Services-Program     0     0     201.00       0nly Charges     0     0     201.00		0. 245690	0					
Only Charges			0		0 125, 693, 846	0		
					0 0		201.00	
202.00         Net Charges (line 200 - line 201)         0         0         125, 693, 846         0         202.00	202.00   Net Charges (line 200 - line 201)		0		0 125, 693, 846	0	202.00	

Heal th	Health Financial Systems PORTER MEMORIAL HOSPITAL In Lieu of Form CMS-25						
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 8/18/2020 12:	
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	_			
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS	-	1 540 075				
	05000 OPERATING ROOM	0	1, 510, 075				50.00
	05100 RECOVERY ROOM	0	C				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	2,400				52.00
	05300 ANESTHESI OLOGY	0	13, 495				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 484, 820				54.00
	05401 ULTRASOUND	0	C				54.01
	05600 RADI OI SOTOPE	0	C				56.00
	05700 CT SCAN	0	C				57.00
	05800 MRI	0	0				58.00
	06000 LABORATORY	0	1, 100, 796				60.00
	06500 RESPIRATORY THERAPY	0	35, 953				65.00
	06600 PHYSI CAL THERAPY	0	205, 120				66.00
	06700 OCCUPATI ONAL THERAPY	0	20, 250				67.00
	06800 SPEECH PATHOLOGY	0	135, 334				68.00
	06900 ELECTROCARDI OLOGY	0	542, 402				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	134, 901				71.00 72.00
	07200 TMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	395, 732				72.00
	07400 RENAL DIALYSIS	0	2, 199, 066				74.00
	03950 ANCI LLARY	0		1			76.00
	03610 SLEEP LAB	0					76.00
	03951 WOUND CARE		282, 627				76.01
	OUTPATIENT SERVICE COST CENTERS		202, 027				70.03
	09000 CLINIC	0	C				90.00
	09100 EMERGENCY	0					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	358, 178				92.00
200.00		0	11, 830, 161				200.00
200.00	Less PBP Clinic Lab. Services-Program	0	,,,,				201.00
00	Only Charges						
202.00		c	11, 830, 161				202. 00

	Financial         Systems         PORTER         MEMORIAL           ATION OF         INPATIENT         OPERATING         COST         COST	Provi der CCN: 15-0035	Period: From 01/01/2019	u of Form CMS-2 Worksheet D-1	
			To 12/31/2019	Date/Time Pre 8/18/2020 12:	pareo 24 pi
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			52, 159 52, 159	
00	Private room days (excluding private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs	52, 159 0	
00	do not complete this line.		rvate room days,	0	0.
00	Semi-private room days (excluding swing-bed and observation b			47, 117	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)			c c	
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	19, 806	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	coom days)	0	10
00	through December 31 of the cost reporting period (see instruc		com days)	0	''
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		o room dave)	0	12
. 00	through December 31 of the cost reporting period	x only (meruaning privat	.e room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
~~	after December 31 of the cost reporting period (if calendar y			0	1 1 4
. 00 . 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	the cost	0.00	20
. 00	reporting period			0.00	20
. 00	Total general inpatient routine service cost (see instruction			44, 218, 880	
. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 10^{-1}$ x line 17)	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23
	x line 18)		5 1 2 2 2 2		
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)		,	-	
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		44, 218, 880	27
. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	, ,		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	tterential (line	44, 218, 880	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
. 00	Adjusted general inpatient routine service cost per diem (see	-		847.77	
~~		( ( ( )		16, 790, 933	39
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		10, 790, 933	

	al Systems F INPATIENT OPERATING COST	PORTER MEMORIA	AL HOSPITAL Provider CO	CN: 15-0035	In Lie eriod:	u of Form CMS- Worksheet D-1			
				F	rom 01/01/2019 o 12/31/2019		epared:		
			Title	XVIII	Hospi tal	PPS			
C	cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
		1.00	2.00	3.00	4.00	5.00			
42.00 NURSER	Y (title V & XIX only)	0	0				42.00		
Intensi	ve Care Type Inpatient Hospital Units								
	IVE CARE UNIT	11, 771, 220	5, 925			5, 691, 896			
	AL INTENSIVE CARE UNIT	3, 761, 659	2, 827	1, 330. 62	0	0			
	RY CARE UNIT						44.00		
	NTENSIVE CARE UNIT						45.00		
	AL INTENSIVE CARE UNIT						46.00		
	SPECIAL CARE (SPECIFY) cost Center Description			l	ļ		47.00		
C	ost center bescription					1.00			
48.00 Progra	n inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			31, 269, 230	48.00		
	Program inpatient costs (sum of lines			ns)		53, 752, 059			
	IROUGH COST ADJUSTMENTS								
	nrough costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	1, 719, 579	50.00		
111)									
	nrough costs applicable to Program inp	atient ancillary	y services (fr	om Wkst. D, su	m of Parts II	1, 316, 373	51.00		
and IV	•					a ac=			
	Program excludable cost (sum of lines					3, 035, 952			
	Program inpatient operating cost exclu		lated, non-pny	si ci an anestne	tist, and	50, 716, 107	53.00		
	AMOUNT AND LIMIT COMPUTATION	52)				L	-		
	n discharges				1	0	54.00		
	amount per discharge					0.00			
	amount (line 54 x line 55)					0			
0	ence between adjusted inpatient operat	ing cost and tar	rget amount (I	ine 56 minus l	ine 53)	0			
	payment (see instructions)	5	5 (		·	0	58.00		
59.00 Lesser	of lines 53/54 or 55 from the cost re	porting period e	ending 1996, u	pdated and com	pounded by the	0.00	59.00		
	basket								
	of lines 53/54 or 55 from prior year					0.00			
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target								
	amount (line 56), otherwise enter zero (see instructions) .00 Relief payment (see instructions)								
	ple Inpatient cost plus incentive paym	ent (see instruc	ctions)			0			
	I INPATIENT ROUTINE SWING BED COST					0	05.00		
	re swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of the	cost reportin	g period (See	0	64.00		
	ctions)(title XVIII only)	-							
	re swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65.00		
	ctions)(title XVIII only)					_			
	Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVIII	only). For	0	66.00		
	ee instructions)	o costs through	December 21 o	f the east ron	arting pariod	0	47 00		
	V or XIX swing-bed NF inpatient routin 12 x line 19)	e costs through	December 31 0	i the cost rep	bitting period	0	67.00		
	V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repor	ting period	0	68.00		
	13 x line 20)			the boot roper	ang portou	l J			
	title V or XIX swing-bed NF inpatient	routine costs (I	line 67 + line	68)		0	69.00		
	I - SKILLED NURSING FACILITY, OTHER N						4		
	d nursing facility/other nursing facil					1	70.00		
	ed general inpatient routine service c		ine 70 ÷ line	2)			71.00		
Ű	n routine service cost (line 9 x line		(line 14	DO 2E)		ł	72.00		
	lly necessary private room cost applic					ł	73.00		
	Program general inpatient routine serv I-related cost allocated to inpatient				rt II column	1	74.00 75.00		
26, li	•	Southe Service	COSTS (ITONEW	or Koneet D, Pd	itir, corumn	l	/ 3.00		
	em capital-related costs (line 75 ÷ li	ne 2)					76.00		
1	n capital-related costs (line 9 x line					l	77.00		
00 0	ate charges to beneficiaries for exces	s costs (from pr	rovider record	s)		l	79.00		
	Program routine service costs for comp		ost limitation	(line 78 minu	s line 79)		80.00		
	ent routine service cost per diem limi						81.00		
	ent routine service cost limitation (I					1	82.00		
	able inpatient routine service costs (		S)			ł	83.00		
84.00 Progra	n inpatient ancillary services (see in					ł	84.00		
5	ation review - physician compensation					1	85.00 86.00		
85.00 Utiliz	Program innationt operating costs (cum					1	1 00.00		
85.00 Utiliz 86.00 Total	Program inpatient operating costs (sum / - COMPUTATION OF OBSERVATION BED PAS:								
85.00 Utiliz 86.00 Total PART IN	/ - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				5, 042	2 87.00		
85.00 Utiliz 86.00 Total PART IN 87.00 Total		S THROUGH COST				5, 042 847. 77			

Health Financial Systems	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 8/18/2020 12:	pared: 24 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	3, 665, 564	44, 218, 880	0. 08289	6 4, 274, 456	354, 335	90.00
91.00 Nursing School cost	0	44, 218, 880	0. 00000	0 4, 274, 456	0	91.00
92.00 Allied health cost	0	44, 218, 880	0. 00000	0 4, 274, 456	0	92.00
93.00 All other Medical Education	0	44, 218, 880	0. 00000	0 4, 274, 456	0	93.00

DMPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035	Peri od:	Worksheet D-1	
		Component CCN: 15-T035	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/18/2020 12:	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		•		
	INPATIENT DAYS			0.450	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 152 3, 152	1. 2.
00	Private room days (excluding swing-bed and observation bed da		ivate room days	3, 152	3.
00	do not complete this line.		rvate room days,	0	J 3.
00	Semi-private room days (excluding swing-bed and observation b	oed days)		3, 152	4.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period	an dave) after December	21 of the cost	0	6
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	Join days) arter becember	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	a the Program (oveluding	swing bod and	2, 146	9
00	newborn days) (see instructions)		Swillg-bed and	2, 140	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period	5	3 ,	0	
8. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	f the cost	0.00	17
3. 00	reporting period	an often December 21 of	the east	0.00	18
5. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	Les aiter December 31 01	the cost	0.00	10
9. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction			3, 537, 358	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	3, 337, 330	22
	5 x line 17)		rig por ou (rino	Ũ	
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
	x line 18)		an and dias	0	24
1.00	Swing-bed cost applicable to NF type services through Decembe $7 \times 10^{-1}$ x line 19)	er 31 of the cost reporti	ng period (iine	0	24
5. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)	1 3			
	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 537, 358	27
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		5,	0	
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x li		· ···-/	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 537, 358	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 122. 26	38
	Program general inpatient routine service cost (line 9 x line			2, 408, 370	
	Medically necessary private room cost applicable to the Progr			0	
. 00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		2, 408, 370	1 41

MPUTATION OF INPATIENT OPERATING COST		L HOSPITAL Provider C	CN: 15-0035	Peri od:	wof Form CMS- Worksheet D-1	
		Component	CCN: 15-T035	From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title	e XVIII	Subprovider -	8/18/2020 12: PPS	24
Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
cost center bescription	Inpatient CostI	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1.00	2.00 C	3.00	4.00 00 0	5.00	) 4
Intensive Care Type Inpatient Hospital U			<u>, 0.</u>	00 0		<u>'</u>
00 INTENSIVE CARE UNIT	0	C			-	
. 01 NEONATAL INTENSIVE CARE UNIT . 00 CORONARY CARE UNIT	0	C	0.	00 0	0	) 4 4
. 00 BURN INTENSIVE CARE UNIT						4
. 00 SURGICAL INTENSIVE CARE UNIT						4
. 00 OTHER SPECIAL CARE (SPECIFY)						4
Cost Center Description					1.00	+
.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			983, 825	5 4
.00 Total Program inpatient costs (sum of li			ons)		3, 392, 195	
PASS THROUGH COST ADJUSTMENTS						
.00 Pass through costs applicable to Program	inpatient routine s	ervices (from	n Wkst. D, su	m of Parts I and	298, 916	5 5
.00 Pass through costs applicable to Program	inpatient ancillary	services (fr	om Wkst. D.	sum of Parts II	43, 703	3 5
and IV)		···· (··	- 1			
2.00 Total Program excludable cost (sum of li		atad '		hatiot!	342, 619	
.00 Total Program inpatient operating cost e medical education costs (line 49 minus l		atea, non-phy	sician anest	netist, and	3, 049, 576	'  <sup>5</sup>
TARGET AMOUNT AND LIMIT COMPUTATION					I	
. 00 Program di scharges					0	
.00   Target amount per discharge .00   Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatient op	erating cost and tar	aet amount (I	ine 56 minus	line 53)	0	
8.00 Bonus payment (see instructions)		g			0	
0.00 Lesser of lines 53/54 or 55 from the cos	t reporting period e	nding 1996, ι	updated and c	ompounded by the	0.00	) 5
market basket 0.00 Lesser of lines 53/54 or 55 from prior y	war cost report upp	lated by the m	arkat baskat		0.00	6 10
.00 If line 53/54 is less than the lower of					0.00	
which operating costs (line 53) are less	than expected costs				-	
amount (line 56), otherwise enter zero (	see instructions)					
<ul><li>Relief payment (see instructions)</li><li>Allowable Inpatient cost plus incentive</li></ul>	navment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST					<u> </u>	10
.00 Medicare swing-bed SNF inpatient routine	costs through Decen	ber 31 of the	e cost report	ing period (See	0	6
instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient routine	costs after Decembe	r 31 of the c	cost reportin	a period (See	0	0 6
instructions) (title XVIII only)			Jost reportin	g period (see		/ 0
.00 Total Medicare swing-bed SNF inpatient r	outine costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	) 6
CAH (see instructions) COO Title V or XIX swing-bed NF inpatient ro	uting goata through	December 21	f the east m	ananting pariod		
.00 Title V or XIX swing-bed NF inpatient ro (line 12 x line 19)	utine costs through	December 31 C	I the cost i	eporting period	0	6
0.00 Title V or XIX swing-bed NF inpatient ro	utine costs after De	cember 31 of	the cost rep	orting period	0	6
(line 13 x line 20)	opt pouting agents ()	ino 47 : 11	× 40)			
2.00 Total title V or XIX swing-bed NF inpati PART III - SKILLED NURSING FACILITY, OTH	•				0	) 6
0.00 Skilled nursing facility/other nursing f				)		7
.00 Adjusted general inpatient routine servi	ce cost per diem (li					7
2.00 Program routine service cost (line 9 x l 3.00 Medically necessary private room cost ap	,	(line 14 v li	no 35)			7
6.00 Medically necessary private room cost ap .00 Total Program general inpatient routine		•	,			7
00 Capital -related cost allocated to inpati				Part II, column		7
26, line 45)	Line 2					7
.00 Per diem capital-related costs (line 75 .00 Program capital-related costs (line 9 x						7
. 00 Inpatient routine service cost (line 74	· ·					7
.00 Aggregate charges to beneficiaries for e	xcess costs (from pr		•			7
.00 Total Program routine service costs for	•	st limitation	n (line 78 mi	nus line 79)		8
.00  Inpatient routine service cost per diem .00  Inpatient routine service cost limitatio						8
.00 Reasonable inpatient routine service cost minitation	• • • •					8
.00 Program inpatient ancillary services (se	•					8
. 00 Utilization review - physician compensat						8
D. 00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		rough 85)				8
. 00 Total observation bed days (see instruct					0	0 8
00 Adjusted general inpatient routine cost	per diem (line 27 ÷	line 2)			0.00	8  0
.00 Observation bed cost (line 87 x line 88)	(see instructions)				0	0 8

Health Financial Systems	PORTER MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
		Component (		To 12/31/2019		pared: 24 pm
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST				•	
90.00 Capital-related cost	439, 039	3, 537, 358	0. 12411	5 0	0	90.00
91.00 Nursing School cost	0	3, 537, 358	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 537, 358	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 537, 358	0. 00000	0 0	0	93.00

	DRIAL HOSPITAL		In Lie	u of Form CMS-2	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0035	Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	narod.
			10 12/31/2019	8/18/2020 12:	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
·		To Charges	Program	Program Costs	
		Ŭ	Charges	(col. 1 x col.	
			0	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			63, 892, 133		30.0
31. 00 03100 I NTENSI VE CARE UNI T			15, 901, 060		31.0
31.01 03101 NEONATAL INTENSIVE CARE UNIT			0		31.0
41. 00 04100 SUBPROVI DER – I RF			0		41.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 07258		4, 521, 743	
51.00 05100 RECOVERY ROOM		0.00000		0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 31516		0	52.0
53. 00 05300 ANESTHESI OLOGY		0. 01192		34, 476	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07061		1, 892, 900	54.0
54. 01 05401 ULTRASOUND		0.00000		0	54.0
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56.0
57.00 05700 CT SCAN		0.00000		0	57.0
58. 00 05800 MRI		0.00000		0	58.0
50. 00 06000 LABORATORY		0. 07520		3, 073, 391	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 07029		1, 870, 488	
56. 00 06600 PHYSI CAL THERAPY		0. 20364		1, 109, 505	66.0
57.00 06700 OCCUPATI ONAL THERAPY		0. 10335			67.0
58.00 06800 SPEECH PATHOLOGY		0. 20208		198, 064	68.0
59. 00 06900 ELECTROCARDI OLOGY		0.07173		2, 009, 608	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08705		793, 018	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13563	53, 595, 727	7, 269, 456	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 14990	30, 047, 335	4, 504, 246	73.0
74. 00 07400 RENAL DIALYSIS		0. 23138	2, 256, 488	522, 108	74.0
76. 00 03950 ANCI LLARY		0.00000	0 0	0	76.0
76. 01 03610 SLEEP LAB		0.00000	0 0	0	76.0
76.03 03951 WOUND CARE		0. 25928	182, 712	47, 374	76.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.00000		0	90.0
91. 00 09100 EMERGENCY		0. 09351			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 24569	2, 752, 640	676, 296	
200.00 Total (sum of lines 50 through 94 and 96 through 98			320, 787, 819	31, 269, 230	
201.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		0		201. 0
202.00 Net charges (line 200 minus line 201)			320, 787, 819		202.0

Health Financial Systems PORTER MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0035	Peri od:	Worksheet D-3	3
	Component	CON. 15 TO25	From 01/01/2019	Data /Tima Dra	norod.
	Component	CCN: 15-T035	To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	Title	e XVIII	Subprovi der –	PPS	21 pm
			I RF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			200.00
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
31. 01   03101   NEONATAL   NTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER - I RF			6 204 709		31.01
43. 00  04300  NURSERY			6, 204, 708		41.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 0725	86 91, 709	6, 657	50.00
51. 00 05100 RECOVERY ROOM		0.0000			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3151		-	
53. 00 05300 ANESTHESI OLOGY		0.0119		25	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0706			
54. 01 05401 ULTRASOUND		0.0000		000	1
56. 00 05600 RADI OI SOTOPE		0.0000			1
57. 00 05700 CT SCAN		0.0000		0	1
58. 00 05800 MRI		0.0000		o o	
60. 00 06000 LABORATORY		0.0752			
65. 00 06500 RESPI RATORY THERAPY		0.0702			1
66. 00 06600 PHYSI CAL THERAPY		0. 2036		379, 335	
67.00 06700 OCCUPATI ONAL THERAPY		0. 1033			
68.00 06800 SPEECH PATHOLOGY		0. 2020			
69. 00 06900 ELECTROCARDI OLOGY		0.0717			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0870	55 790	69	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1356	35 12, 509	1, 697	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1499	05 1, 122, 905	168, 329	73.00
74. 00 07400 RENAL DI ALYSI S		0. 2313	81 67, 320	15, 577	74.00
76. 00 03950 ANCI LLARY		0.0000	00 0	0	76.00
76. 01 03610 SLEEP LAB		0.0000	00 0	0	76.01
76.03 03951 WOUND CARE		0. 2592	80 0	0	76.03
OUTPATIENT SERVICE COST CENTERS				•	
90. 00 09000 CLINIC		0.0000		0	90.00
91. 00 09100 EMERGENCY		0. 0935	12 16, 686	1, 560	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2456	90 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			7, 142, 958	983, 825	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	6 (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			7, 142, 958		202.00

NDATI		HOSPI TAL	CN 15 0025			2552-
NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0035	Period: From 01/01/2019	Worksheet D-3	
				To 12/31/2019	Date/Time Pre	pared
					8/18/2020 12:	24 pn
		Titl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0.00	03000 ADULTS & PEDIATRICS		1	16, 273, 786		30.
1.00	03100 INTENSIVE CARE UNIT			3, 340, 143		30.
1.00	03101 NEONATAL INTENSIVE CARE UNIT			8, 315, 032		31.
1.00	04100 SUBPROVIDER - IRF			0, 315, 032		41.
3.00	04300 NURSERY			1, 384, 943		41.
3.00	ANCI LLARY SERVI CE COST CENTERS			1, 384, 943		43.
0. 00	05000 OPERATI NG ROOM		0.0725	36 14, 229, 949	1, 032, 895	50.
1.00	05100 RECOVERY ROOM		0.0000		1,032,075	51.
2.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3151		1, 527, 319	
3.00	05300 ANESTHESI OLOGY		0.0119		13, 248	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0.0706		513, 538	
4.00	05401 ULTRASOUND		0.0000		0	54.
6.00	05600 RADI OI SOTOPE		0.0000		0	56.
7.00	05700 CT SCAN		0.0000		0	57.
8.00	05800 MRI		0.0000		0	58.
0.00	06000 LABORATORY		0.07520		-	
5.00	06500 RESPI RATORY THERAPY		0.0702		277, 406	65.
6. 00	06600 PHYSI CAL THERAPY		0. 2036			
7.00	06700 OCCUPATI ONAL THERAPY		0. 1033			67.
8.00	06800 SPEECH PATHOLOGY		0. 2020			
9.00	06900 ELECTROCARDI OLOGY		0.0717		383, 795	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0870		140, 623	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1356			
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 14990			
4.00	07400 RENAL DI ALYSI S		0. 2313		63, 459	
6.00	03950 ANCI LLARY		0. 00000		03,437	76.
6. 01	03610 SLEEP LAB		0.0000		0	76.
6.03	03951 WOUND CARE		0. 2592		-	
0.05	OUTPATI ENT SERVI CE COST CENTERS		0.23720	50 55,007	14, 470	/0.
0.00	09000 CLINIC		0.0000	0 00	0	90.
1.00	09100 EMERGENCY		0.0935			
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2456			
2.00			0.2100	72, 399, 788	7, 754, 751	
201.00		(line 61)		12, 377, 700	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	200.
	Net charges (line 200 minus line 201)		1	0		202.

Health Financial Systems PORTER	MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0035	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T035	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT			0		31.01
41. 00 04100 SUBPROVIDER - IRF			593, 475		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 07258		0	
51.00 05100 RECOVERY ROOM		0.0000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 31510		0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.01192		0 1, 251	
54. 00  05400  RADI OLOGY-DI AGNOSTI C 54. 01  05401  ULTRASOUND		0. 0706		1, 251	
56. 00 05600 RADI 0I SOTOPE		0.00000		0	
57. 00 05700 CT SCAN		0.0000		0	1
58. 00 05800 MRI		0.0000		0	
60. 00 06000 LABORATORY		0.07520		4, 926	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 07029		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 20364	18 189, 705	38, 633	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1033		18, 568	67.00
68.00 06800 SPEECH PATHOLOGY		0. 20208		14, 467	
69. 00 06900 ELECTROCARDI OLOGY		0.07173		102	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT		0.0870		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13563		0 9, 870	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S		0. 14990 0. 23138		9,870	1
76. 00 03950 ANCI LLARY		0. 23130		0	1
76. 01   03610  SLEEP LAB		0.00000		0	
76. 03 03951 WOUND CARE		0. 25928		0	1
OUTPATIENT SERVICE COST CENTERS		0.20720	0	0	, 0. 00
90. 00 09000 CLINIC		0.0000	0 00	0	90.00
91.00 09100 EMERGENCY		0. 0935		8	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 2456	90 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 throu			591, 530	87, 825	200. 00
201.00 Less PBP Clinic Laboratory Services-Program on	ly charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	591, 530		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 8/18/2020 12:	
		Title XVIII	Hospi tal	PPS	<u>z                                    </u>
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	see	0 27, 975, 745	1. ( 1. (
02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	11, 160, 696	1. (
03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1. (
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1. (
00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. (
01	Outlier reconciliation amount			0	2.0
02 03	Outlier payment for discharges for Model 4 BPCI (see instruct Outlier payments for discharges occurring prior to October 1	-		0 1, 457, 364	2.0
03	Outlier payments for discharges occurring on or after October			123, 361	
00	Managed Care Simulated Payments			15, 987, 539	
00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	224.19	
	Indirect Medical Education Adjustment				
00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.0
00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	on to the cap for	0.00	6. (
00	MMA Section 422 reduction amount to the IME cap as specified			0.00	
01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.
00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.
01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.
02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	nes (8, 8,01 and 8,02)	see	0.00	9.
0.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your recom	ds	0.00	
1.00	FTE count for residents in dental and podiatric programs.			0.00	
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00	
4. 00	Total allowable FTE count for the penultimate year if that ye	ear ended on or after Sep	otember 30, 1997,	0.00	
	otherwise enter zero.				
5.00	Sum of lines 12 through 14 divided by 3.			0.00	
5.00	Adjustment for residents in initial years of the program			0.00	
7.00 8.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	isure		0.00 0.00	
	Current year resident to bed ratio (line 18 divided by line 4			0.00	
	Prior year resident to bed ratio (see instructions)			0. 000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
. 00	IME payment adjustment (see instructions)			0	
. 01	IME payment adjustment - Managed Care (see instructions)			0	22.
8. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.
	(f)(1)(iv)(C).				
. 00 5. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0.00 0.00	
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.
. 00	IME payments adjustment factor. (see instructions)			0.00000	27.
. 00	IME add-on adjustment amount (see instructions)			0	
. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
. 00 . 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	)1)		0	29. 29.
	Disproportionate Share Adjustment				
. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	2.19	
. 00	Percentage of Medicaid patient days (see instructions)			16.26	
2.00	Sum of lines 30 and 31			18.45	
3.00	Allowable disproportionate share percentage (see instructions			4.74	33

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2019	Worksheet E Part A	
			To 12/31/2019	Date/Time Prep	
		Title XVIII	Hospi tal	8/18/2020 12:2 PPS	24 piii
			Prior to 10/1		
			1.00	2.00	
05 00	Uncompensated Care Adjustment		0.070.070.447	0.050.500.00/	1 05 00
35.00 35.01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 272, 872, 447 0. 000244290	8, 350, 599, 096 0. 000183986	•
35.01	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (so		1, 536, 393	•
00.02	instructions)		2, 020, 700	1,000,070	00.02
35.03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	1, 511, 582	386, 197	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.		1, 897, 779		36.00
40.00	Additional payment for high percentage of ESRD beneficiary d				1 40 00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685, (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS	-DRGs 652, 682, 683, 68	4 0		41.01
42.00	an 685. (see instructions)	ify for adjustment)	0.00		40.00
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6		0.00		42.00
-5.00	instructions)		0		-5.00
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
	days)				
45.00	Average weekly cost for dialysis treatments (see instruction		0.00		45.00
46.00 47.00	Total additional payment (line 45 times line 44 times line 4 Subtotal (see instructions)	1.01)	43, 078, 712		46.00
47.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	43, 078, 712		47.00
10.00	only. (see instructions)		0		10.00
				Amount	
40.00		<u>``</u>		1.00	10.00
49.00 50.00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I a		\ \	43, 078, 712 3, 361, 174	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. 1 a		)	3, 301, 174	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, I			0	
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	
54.01	Islet isolation add-on payment			0	
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int			0	55.00 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35)	0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt.			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			46, 439, 886	59.00
60.00	Primary payer payments			8, 621	
61.00	Total amount payable for program beneficiaries (line 59 minu	is line 60)		46, 431, 265	
62.00 63.00	Deductibles billed to program beneficiaries			4, 055, 576	
63.00 64.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			296, 436 201, 195	
65.00	Adjusted reimbursable bad debts (see instructions)			130, 777	
66.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		-42, 440	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			42, 210, 030	67.00
68.00	Credits received from manufacturers for replaced devices for			0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	. (For SCH see instruction	ns)	0	
70.00 70.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	
70. 30	Demonstration payment adjustment amount before sequestration	, , ,		0	70. 30
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	
70.89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70.89
	HSP bonus payment HVBP adjustment amount (see instructions)			0	•
70. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70. 90 70. 91					
70. 90 70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	
70. 90 70. 91				0 -44, 554 -159, 330	70.93

ALCULATION OF RELABORSEMENT SETTIEMENT	Provider C	CN: 15-0035	Period:	Worksheet E	2552-1
the corresponding federal year for the period prior to 10/1 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or Low Volume Payment-3 9 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus line Sequestration adjustment (see instructions) 2 Demonstration payment adjustment amount after sequestration 3 Sequestration adjustment-PARHM pass-throughs 1 Interim payments 1 Interim payments 2 Interim payments 1 Interim payments 2 Interim payments 3 Entative settlement (for contractor use only) 4 Tentative settlement-PARHM (for contractor use only) 5 Balance due provider/program (line 71 minus lines 71.01, 71 73) 6 Balance due provider/program-PARHM (see instructions) 6 Protested amounts (nonallowable cost report items) in accor 7 CMS Pub. 15-2, chapter 1, §115.2 7 O BE COMPLETED BY CONTRACTOR (lines 90 through 96) 7 Operating outlier amount from Wkst. E, Pt. A, line 2, or su 8 plus 2.04 (see instructions) 7 Capital outlier from Wkst. L, Pt. I, line 2 7 Operating outlier reconciliation adjustment amount (see instruction 7 The rate used to calculate the time value of money (see inst 7 Time value of money for operating expenses (see instruction 7 Time value of money for operating expenses (see instruction 7 Time value of money for capital related expenses (see instruction 7 Time value of money for HSP bonus payment (see instruction 7 Time value of money for HSP bonus payment (see instruction 8 HSP Bonus Payment factor (see instructions) 8 HVBP Adjustment factor (see instructions) 8 HVBP Adjustment factor (see instructions) 90 HVBP adjustment factor (see instructions) 90 HKR adjustment factor (see instructions) 90 Gase-mix adjustment factor (see instructions) 90 Case-mix adjustment factor (see instructions) 90 Case-mix adjustment factor (see in		CN. 13 0033	From 01/01/2019	Part A	
			To 12/31/2019	Date/Time Pre 8/18/2020 12:	
	Title	× XVIII	Hospi tal	PPS	24 piii
	· ·	FFY	(уууу)	Amount	
0.0/ Law values adjustment for fadaral figsal ware (www.) (Fat			0	1.00	70.0
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10	er in column 0 /1)		0	0	70.9
			0	0	70.9
	r after 10/1)				
5				0	
	$m_{00}$ (0 $g$ 70)			0	
	nes 69 & 70)			42, 006, 146 840, 123	
	on			040, 123	
				-	71.0
				41, 155, 064	72.0
					72.0
				0	
	71 02 72 and			10, 959	73.C
	71.02, 72, anu			10, 939	/4.0
					74. C
	ordance with			4, 749, 526	75. C
				0	90.0
	Sulli 01 2.03			0	90.0
				0	91. (
	nstructions)			0	92.0
				0	
5.				0.00	
				0	
b. OUTTIME value of money for capital related expenses (see this			Drior to 10/1	0n/After 10/1	90.0
			1.00	2.00	
			1.00	2.00	
00.00 HSP bonus amount (see instructions)				2.00	100. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions)	tions)		1.00 0 0.000000000	2.00 0 0.000000000	101. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct	tions)		1.00	2.00 0 0.000000000	101. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct	tions)		1.00 0 0.000000000	2.00 0 0.000000000	101. ( 102. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions)	i ons)		1.00 0 0.0000000000 0	2.00 0.000000000 0 0.0000 0.0000	101. ( 102. ( 103. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demo	ions) onstration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000	101. ( 102. ( 103. ( 104. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration	ions) onstration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000	101. ( 102. ( 103. ( 104. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	ions) onstration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000	101. ( 102. ( 103. ( 104. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	ions) onstration) Adju n period under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000	101. ( 102. ( 103. ( 104. ( 200. (
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) 04.00 Is this the first year of the current 5-year demonstration 05.00 Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ions) onstration) Adju n period under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000	101. 0 102. 0 103. 0 104. 0 200. 0
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment for HSP bonus payment (see instruct HRR Adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02. 00 Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> </ul>	ions) onstration) Adju n period under t line 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment for HSP bonus payment (see instruct HRR Adjustment for HSP bonus payment (see instruct HRR adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instruction)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instruction)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instruction)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instruction)</li> <li>05. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 00 Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Computation of Demonstration Target Amount Limitation (N/A)</li> </ul>	ions) onstration) Adju n period under t line 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. (
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo 00. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Computation of Demonstration Target Amount Limitation (N/A period)</li> </ul>	ions) onstration) Adju n period under t line 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. (
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Ocentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>04. 00 Medicare target amount</li> </ul>	ions) onstration) Adju n period under t line 49)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. (
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>04. 00 Medicare target amount</li> <li>05. 00 Case-mix adjusted target amount (line 203 times line 204)</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 203. ( 205. (
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment factor (see instructions)</li> <li>05. 00 HRR adjustment factor (see instructions)</li> <li>06. 00 HRR adjustment factor (see instructions)</li> <li>07. 00 HRR adjustment factor (see instructions)</li> <li>08. 00 HRR adjustment factor (see instructions)</li> <li>09. 00 HRR adjustment factor (see instructions)</li> <li>00. 00 HRR adjustment factor (see instructions)</li> <li>01. 00 HRR adjustment amount for HSP bonus payment (see instruction)</li> <li>02. 00 HRR adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment for HSP bonus payment (see instruction)</li> <li>04. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare di scharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>04. 00 Medicare target amount</li> <li>05. 00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06. 00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>06. 00 Medicare to Medicare Part A Inpatient Reimbursement</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 203. ( 205. (
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment factor (see instructions)</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>07.00 Program reimbursement under the §410A Demonstration (see inf</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 205. ( 205. ( 206. ( 207. (
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment factor (see instructions)</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare di scharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06.00 Medicare part A Inpatient Reimbursement</li> <li>07.00 Program reimbursement under the §410A Demonstration (see instruction (see</li></ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 204. ( 205. ( 206. ( 206. ( 206. ( 206. ( 208. (
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>01.00 Medicare target amount</li> <li>02.00 Medicare target amount</li> <li>03.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 202 times line 204)</li> <li>01.00 Medicare Part A Inpatient Reimbursement</li> <li>01.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>01.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>03.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 200. ( 201. ( 202. ( 203. ( 204. ( 205. ( 206. ( 206. ( 207. ( 208. ( 209. (
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment factor (see instructions)</li> <li>04.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>04.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>05.00 Medicare Part A Inpatient Reimbursement</li> <li>07.00 Part Mathematican Costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions)</li> <li>08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. Of Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>09.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>00.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>01.00 Reserved for future use</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions) . A, line 59)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 103. ( 200. ( 200. ( 202. ( 203. ( 204. ( 205. ( 204. ( 205. ( 206. ( 206. ( 207. ( 208. ( 209. ( 209. ( 209. ( 200. ()))))))))))))))))))))))))))))))))))
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>04.00 HVBP adjustment factor (see instructions)</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>04.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06.00 Medicare Part A Inpatient Reimbursement</li> <li>07.00 Program reimbursement under the §410A Demonstration (see in Adjustment to Medicare IPPS payments (see instructions)</li> <li>07.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions) . A, line 59)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. ( 102. ( 103. ( 103. ( 200. ( 200. ( 202. ( 203. ( 204. ( 205. ( 204. ( 205. ( 206. ( 206. ( 207. ( 208. ( 209. ( 209. ( 209. ( 200. ()))))))))))))))))))))))))))))))))))
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>04. 00 Medicare target amount</li> <li>05. 00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06. 00 Medicare inpatient routine cost cap (line 202 times line 204)</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions) . A, line 59) ons)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
<ul> <li>00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01. 00 HVBP adjustment factor (see instructions)</li> <li>02. 00 HVBP adjustment factor (see instructions)</li> <li>03. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment factor (see instructions)</li> <li>04. 00 HRR adjustment for HSP bonus payment (see instructi Rural Community Hospital Demonstration Project (§410A Demo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>03. 00 Case-mix adjustment factor (see instructions)</li> <li>04. 00 Medicare target amount</li> <li>05. 00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06. 00 Medicare inpatient service costs (from Wkst. E, Pt. Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>07. 00 Program reimbursement under the §410A Demonstration (see in Adjustment to Medicare IPPS payments (see instructions)</li> <li>03. 00 Case-nix adjustment service costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	ions) onstration) Adju n period under t line 49) A in first year 205) instructions) . A, line 59) ons)	he 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 rati on	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 204. ( 205. ( 207. ( 208. ( 209. ( 209. ( 209. ( 201. ()

	Financial         Systems         PORTER         MEMORIAL         Hi           ATION OF         REIMBURSEMENT         SETTLEMENT         F	OSPITAL Provider CCN: 15-0035	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2019 To 12/31/2019	Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	8/18/2020 12: PPS	
		II the Aviiii		113	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			28, 120	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		35, 234, 764	
3.00 4.00	OPPS payments Outlier payment (see instructions)			33, 409, 241 136, 745	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, col. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			28, 120	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			187, 921	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			187, 921	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for	payment for services of	n a chargebasis	0	
17 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
17.00 18.00	Total customary charges (see instructions)			187, 921	17.00 18.00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	159, 801	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			28, 120 0	
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			33, 545, 986	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			57, 423	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr		6, 011, 859	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of lines 22	and 23] (see	27, 504, 824	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			27, 504, 824 26, 326	
32.00	Subtotal (line 30 minus line 31)			27, 478, 498	
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. 1-5, line 11)	S)		0	33. 00
34.00	Allowable bad debts (see instructions)			541, 265	
35.00	Adjusted reimbursable bad debts (see instructions)			351, 822	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ctions)		313, 914 27, 830, 320	
38.00	MSP-LCC reconciliation amount from PS&R			-403	
39.00 20.E0	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			27, 830, 723 556, 614	
40.02	Demonstration payment adjustment amount after sequestration			0	40. 02
40.03	Sequestration adjustment-PARHM pass-throughs Interim payments			27, 352, 204	40.03 41.00
41.00	Interim payments-PARHM			21, 332, 204	41.00
42.00	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-78, 095	42.01 43.00
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0.00	
94 00	Total (sum of lines 91 and 93)			0	94.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	L HOSPITAL Provider CCN: 15-0035	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part B	
		Component CCN: 15-T035	To 12/31/2019	Date/Time Pre 8/18/2020 12:2	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		331 2, 451	1. 2.
. 00	OPPS payments			1, 137	
. 00	Outlier payment (see instructions)			0	
. 01 . 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	45
. 00	Line 2 times line 5			0.000	6
. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
. 00 . 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
0.00	Organ acqui si ti ons	14, 661. 16, 1116 200		0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			331	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
2.00	Ancillary service charges			2, 209	
3.00 4.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	line 69)		0 2, 209	13
4.00	Customary charges			2,207	14
5.00	Aggregate amount actually collected from patients liable for			0	
6. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		n a chargebasis	0	16
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17
8.00	Total customary charges (see instructions)			2,209	
9.00	Excess of customary charges over reasonable cost (complete or instructions)	niy it line 18 exceeds ii	ne II) (see	1, 878	19
0. 00	Excess of reasonable cost over customary charges (complete or	nlyifline 11 exceeds li	ne 18) (see	0	20
1. 00	instructions) Lesser of cost or charges (see instructions)			331	21
2.00	Interns and residents (see instructions)			0	22
3.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			1, 137	24
5.00	Deductibles and coinsurance amounts (for CAH, see instruction	ns)		191	25
6.00	Deductibles and Coinsurance amounts relating to amount on lin			0	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of Thes 22	and 23] (See	1, 277	27
8.00	Direct graduate medical education payments (from Wkst. E-4, I			0	
9.00 0.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	)		0 1, 277	
1.00	Primary payer payments			1, 2/7	31
2.00	Subtotal (line 30 minus line 31)	1050)		1, 277	32
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	I CES)		0	33
4.00	Allowable bad debts (see instructions)			348	
5.00	Adjusted reimbursable bad debts (see instructions)	tt!		226	
6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see ins: Subtotal (see instructions)	tructions)		310 1, 503	
8.00	MSP-LCC reconciliation amount from PS&R			0	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	20)		0	39
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration			0	39 39
9. 98	Partial or full credits received from manufacturers for repla		tions)	0	39
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
0. 00 0. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 503 30	
0. 02	Demonstration payment adjustment amount after sequestration			0	
D. 03 1. 00	Sequestration adjustment-PARHM pass-throughs			1 240	40
1.00	Interim payments Interim payments-PARHM			1, 360	41 41
2.00	Tentative settlement (for contractors use only)			0	42
2.01 3.00	Tentative settlement-PARHM (for contractor use only)			113	42 43
3.00 3.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			113	43
4.00	Protested amounts (nonallowable cost report items) in accorda \$115.2	ance with CMS Pub. 15-2,	chapter 1,	0	
). 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
1.00	Outlier reconciliation adjustment amount (see instructions)			0	91
	The rate used to calculate the Time Value of Money			0.00	
2.00 3.00	Time Value of Money (see instructions)			0	93

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prep 8/18/2020 12:2	bared 24 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		41, 111, 3 <i>6</i>	0 0	27, 352, 204 0	1.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.0
01	ADJUSTMENTS TO PROVIDER	07/17/2019	43, 70	00	0	3.0
. 02				0	0	3. C
. 03				0	0	3. (
. 04 . 05				0	0	3. 3.
05	Provider to Program			0	0	э.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		40.70	0	0	3. 3.
99	3. 50-3. 98)		43, 70	0	U	з.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		41, 155, 06	54	27, 352, 204	4.
	TO BE COMPLETED BY CONTRACTOR	1				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0 0	5. 5.
51 52				0	0	5. 5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
D1	SETTLEMENT TO PROVIDER		10, 95		0	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		41, 166, 02	0	78, 095 27, 274, 109	6. 7.
	Total modecare program traditity (see first detroits)		<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	_

	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0035 CCN: 15-T035	Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovider -	PPS	24 pi
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 530, 7	63 0	1, 360 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
)4				0	0	3
15				0	0	3
~	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	2
0	ADJUSTMENTS TU PRUGRAM			0	0	3
52				0	0	3
3				0	0	3
54				0	0	3
9	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 530, 7	63	1, 360	4
	TO BE COMPLETED BY CONTRACTOR		<u> </u>			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
1	TENTATI VE TO PROVI DER			0	0	5
2				0	0	5
)3				0	0	5
	Provider to Program		1			
0	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on				0	6
	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		8, 9	16	113	6
)2	SETTLEMENT TO PROGRAM		0	0	0	6
00	Total Medicare program liability (see instructions)		3, 539, 6		1,473	7
				Contractor	NPR Date	
			)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0035 Period: Worksheet E-1	
From 01/01/2019 Part II To 12/31/2019 Date/Time Prep	ared
8/18/2020 12:2	
Title XVIII Hospital PPS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I	7.00
line 168	0.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00 9.00
9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	9.00 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	10.00
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCU		RIAL HOSPITAL		u of Form CMS-2	
CALCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2019	Worksheet E-3 Part III	
		Component CCN: 15-T035	To 12/31/2019	Date/Time Pre	
		Title XVIII	Subprovider -	8/18/2020 12: PPS	24 piii
			IRF		
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3, 541, 724	1.0
2.00 3.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0243	2.0 3.0
3.00 4.00	Inpatient Rehabilitation LIP Payments (see instructions) Outlier Payments			100, 231 20, 788	4.0
5.00	Unweighted intern and resident FTE count in the most rece	at cost reporting period en	ding on or prior	0.00	5.0
5.00	to November 15, 2004 (see instructions)	it cost reporting period cil		0.00	5.0
5. 01	Cap increases for the unweighted intern and resident FTE	count for residents that wer	e displaced by	0.00	5.0
	program or hospital closure, that would not be counted with	thout a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	7.0
8.00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents with	hin the new program growth p	eriod of a "new	0.00	8. 0
0.00	teaching program" (see instructions)	in the new program growth p		0.00	0.0
9.00	Intern and resident count for IRF PPS medical education a	djustment (see instructions)		0.00	9.0
10.00	Average Daily Census (see instructions)			8.635616	10. 0
11.00	Teaching Adjustment Factor (see instructions)			0.00000	11.0
12.00	Teaching Adjustment (see instructions)			0	12.0
13.00	Total PPS Payment (see instructions)			3, 662, 743	13.0
14.00	Nursing and Allied Health Managed Care payments (see inst	ruction)		0	14.0
15.00	Organ acquisition (DO NOT USE THIS LINE)			_	15.0
16.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	16.0
17.00	Subtotal (see instructions)			3, 662, 743	
18.00 19.00	Primary payer payments Subtotal (line 17 less line 18).			0 3, 662, 743	18. 0 19. 0
20.00	, , , , , , , , , , , , , , , , , , , ,			3, 002, 743 8, 184	
21.00	Subtotal (line 19 minus line 20)			3, 654, 559	
22.00				53, 028	
23.00				3, 601, 531	
24.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		15, 979	24.0
25.00				10, 386	25.0
26.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		14, 663	26.0
27.00				3, 611, 917	27.0
28.00	Direct graduate medical education payments (from Wkst. E-	4, line 49)		0	28.0
29.00				0	29.0
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ti ana)		0	31.00
31.50				0	31.50
31.99 32.00	1 3 3			0 3, 611, 917	31.99 32.00
32.00	Sequestration adjustment (see instructions)			3, 611, 917 72, 238	
32.01		n			32.0
33.00				3, 530, 763	
34.00				0,000,700	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01,	32.02, 33, and 34)		8, 916	
36.00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub. 15-2,	chapter 1,	11, 334	36.00
	§115.2				
50.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4			20, 788	50.00
51.00	Outlier reconciliation adjustment amount (see instruction	5)		20, 788	
52.00	3	-,		-	52.00
	Time Value of Money (see instructions)				53.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider CC	F	Period: From 01/01/2019	Worksheet G	
l y)				To 12/31/2019	Date/Time Pre 8/18/2020 12:	
		General Fund	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund	
	CURRENT ASSETS			1		
00 00	Cash on hand in banks Temporary investments	-55, 474 0	(		0	
00	Notes receivable	0	(		0	2. 3.
00	Accounts receivable	75, 981, 026	(	-	0	4.
00	Other receivable	0	(	0 0	0	5.
00	Allowances for uncollectible notes and accounts receivable	-18, 764, 691	(	-	0	
00 00	Inventory Prepaid expenses	10, 138, 089 1, 206, 761	(	-	0	
00	Other current assets	-22, 608	(	° I	0	
. 00	Due from other funds	0	(		0	10.
. 00	Total current assets (sum of lines 1-10)	68, 483, 103	(	0 0	0	11.
	FI XED ASSETS			1		
. 00	Land	11, 615, 241	(		0	12.
. 00 . 00	Land improvements Accumulated depreciation	4, 920, 709 -2, 861, 541	(		0	13.
. 00	Buildings	191, 907, 250	(		0	
. 00	Accumulated depreciation	-35, 811, 349	(	-	0	16.
. 00	Leasehold improvements	7, 578, 312	(	0 0	0	17.
. 00	Accumulated depreciation	-2, 829, 163	(	0 0	0	18.
. 00	Fixed equipment	6, 896, 026	(	-	0	19
. 00	Accumulated depreciation	-5, 283, 636	(	-	0	20
. 00 . 00	Automobiles and trucks Accumulated depreciation	254, 940 -213, 751	(	-	0	21
	Major movable equipment	58, 526, 828	(	-	0	
	Accumul ated depreciation	-49, 927, 424	(	-	0	24
	Minor equipment depreciable	17, 552, 199	(	0 0	0	25
	Accumulated depreciation	-14, 663, 330	(	-	0	26
. 00	HIT designated Assets	0	(	° °	0	27
	Accumulated depreciation	0	(	-	0	28
. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 187, 661, 311	(		0	29
. 00	OTHER ASSETS	107,001,011				
. 00	Investments	0	(	0 0	0	31
. 00	Deposits on leases	0	(		0	32.
. 00	Due from owners/officers	0	(	-	0	33
. 00	Other assets	18, 179, 103	(		0	34
. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	18, 179, 103 274, 323, 517	(	-	0	35
	CURRENT LI ABI LI TI ES	274, 323, 317			0	30
	Accounts payable	10, 519, 637	(		0	37
. 00	Salaries, wages, and fees payable	9, 700, 394	(		0	
00 00	Payroll taxes payable Notes and Loans payable (short term)	191– 1, 978, 017	(		0	
. 00	Deferred income	1, 970, 017	(		0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	-228, 024, 480	(	0 0	0	
. 00	Other current liabilities	2, 575, 666	(	-	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	-203, 250, 957	(	0 0	0	45
. 00	LONG TERM LIABILITIES Mortgage payable	0	(	0 0	0	46
. 00	Notes payable	0	(		0	
00	Unsecured Loans	0	(	-	0	
00	Other long term liabilities	23, 421, 352	(	-	0	49
00	Total long term liabilities (sum of lines 46 thru 49)	23, 421, 352	(	-	0	50
00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	-179, 829, 605	(	0 0	0	51
00	General fund balance	454, 153, 122				52
00	Specific purpose fund		(			53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
				1		1
00	Total fund balances (sum of lines 52 thru 58)	454, 153, 122	(	0 0	0	59

Heal th	Financial Systems	PORTER MEMORIA	AL HOSPITAL			In Lie	u of Form CMS	-2552	2-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0035		eriod: com 01/01/2019 o 12/31/2019	Worksheet G- Date/Time Pr 8/18/2020 12	1 eparo : 24	ed:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun	b	
1.00	Fund balances at beginning of period	1.00	2.00 410,287,098	3.00		4.00	5.00	1	. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43, 866, 024			0			2.00
3.00	Total (sum of line 1 and line 2)		454, 153, 122			0			3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0				1.00 5.00
6.00		0			0				5. 00 5. 00
7.00		0			0				. 00
8.00 9.00		0			0				3.00 9.00
10.00	Total additions (sum of line 4-9)	0	0		U	0			). 00
11.00	Subtotal (line 3 plus line 10)		454, 153, 122			0			. 00
12.00 13.00	Deductions (debit adjustments) (specify)	0			0				2.00
13.00		0			0				1.00
15.00		0			0			D 15	5.00
16.00		0			0				b. 00
17.00 18.00	Total deductions (sum of lines 12–17)	0	0		U	0			7.00 3.00
19.00	Fund balance at end of period per balance		454, 153, 122			0		19	9.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				_	
		6.00	7.00	8.00					
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0				. 00
3.00	Total (sum of line 1 and line 2)	0			0			-	3.00
4.00	Additions (credit adjustments) (specify)		0						1.00
5.00 6.00			0						5.00 5.00
7.00			0						7.00
8.00			0						3. 00
9.00 10.00	Total additions (sum of line 4-9)	0	0		0				9.00 ).00
11.00	Subtotal (line 3 plus line 10)	0			0				. 00
12.00	Deductions (debit adjustments) (specify)		0		-				2.00
13.00			0						3.00
14.00 15.00			0						1.00 5.00
16.00			0						5. 00 5. 00
17.00			0						. 00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0				3.00 9.00
17.00	sheet (line 11 minus line 18)	0			U			19	, 00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0035	Period: From 01/01/2019 To 12/31/2019		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	'		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					1
. 00	Hospi tal		155, 244, 5	91	155, 244, 591	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF		9, 118, 9	98	9, 118, 998	
1.00	SUBPROVIDER		.,			4.00
5.00	Swing bed - SNF			0	0	
5.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	7.00
3.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		164, 363, 5	80	164, 363, 589	
10.00	Intensive Care Type Inpatient Hospital Services		104, 303, 3	07	104, 303, 307	10.00
1.00	INTENSIVE CARE UNIT		32, 911, 8	26	32, 911, 826	11.00
1.01	NEONATAL INTENSIVE CARE UNIT		16, 489, 3		16, 489, 305	
12.00	CORONARY CARE UNIT		10, 409, 5	00	10, 407, 303	12.00
12.00	BURN INTENSIVE CARE UNIT					13.00
4.00	SURGICAL INTENSIVE CARE UNIT					14.00
14.00	OTHER SPECIAL CARE (SPECIFY)					15.00
		Linoc	40 401 1	21	40 401 121	
6.00	Total intensive care type inpatient hospital services (sum of 11-15)	rnes	49, 401, 1	31	49, 401, 131	16.00
7.00	Total inpatient routine care services (sum of lines 10 and 16)		213, 764, 7	20	213, 764, 720	17.00
17.00	Ancillary services		709, 903, 6		1, 735, 774, 581	
18.00	Outpatient services					
			64, 315, 0	53 149, 625, 970 0 0		
20.00	RURAL HEALTH CLINIC			0 0		
22.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	21.00
	HOME HEALTH AGENCY					
23.00	AMBULANCE SERVICES					23.00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)		007 000 0		0	1
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to WKST.	987, 983, 3	90 1, 175, 496, 934	2, 163, 480, 324	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			270 242 450	1	29.00
29.00 30.00	ADD (SPECIFY)			279, 262, 450		30.00
	ADD (SELVIET)			0		
31.00						31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			(	י 	36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
10.00				0		40.00
1.00				0		41.00
12.00	Total deductions (sum of lines 37-41)			(		42.00
13.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		279, 262, 450	) I	43.00

Heal th	Financial Systems POF	TER MEMORIAL HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Prov	ider CCN: 15-0035		Worksheet G-3	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	arodi
				10 12/31/2019	8/18/2020 12: 2	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, o				2, 163, 480, 324	1.00
2.00	Less contractual allowances and discounts on pati	ents' accounts			1, 841, 272, 739	2.00
3.00	Net patient revenues (line 1 minus line 2)				322, 207, 585	3.00
4.00	Less total operating expenses (from Wkst. G-2, Pa				279, 262, 450	4.00
5.00	Net income from service to patients (line 3 minus	s line 4)			42, 945, 135	5.00
	OTHER I NCOME			1		
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneous of	communication servi	ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00					0	11.00
12.00					0	12.00
13.00					0	13.00
	Revenue from meals sold to employees and guests				0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical supplie		itients		0	16.00
17.00					0	17.00
18.00					0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				0	19.00
20.00		anteen			0	20.00
21.00					0	21.00
22.00					0	22.00
23.00	Governmental appropriations				0	23.00
24.00					920, 889	
	Total other income (sum of lines 6-24)				920, 889	
	Total (line 5 plus line 25)				43, 866, 024	
	OTHER EXPENSES (SPECI FY)				0	27.00
	Total other expenses (sum of line 27 and subscrip				0	28.00
29.00	Net income (or loss) for the period (line 26 minu	us line 28)			43, 866, 024	29.00

ALCULA	TION OF CAPITAL PAYMENT	Provider CCN: 15-0035	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III	
			To 12/31/2019	Date/Time Pre 8/18/2020 12:	
		Title XVIII	Hospi tal	PPS	- p.
				1.00	
F	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
	Capital DRG other than outlier			3, 126, 392	
	Model 4 BPCI Capital DRG other than outlier			0	
	Capital DRG outlier payments			115, 666	
	Model 4 BPCI Capital DRG outlier payments			0	2.
	Total inpatient days divided by number of days in the co	st reporting period (see inst	ructions)	154.66	
	Number of interns & residents (see instructions)			0.00	
	Indirect medical education percentage (see instructions)			0.00	
	Indirect medical education adjustment (multiply line 5 b 1.01)(see instructions)	y the sum of lines 1 and 1.01	, columns 1 and	0	6.
	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	t A patient days (Worksheet E	, part A line	2.19	7.
	Percentage of Medicaid patient days to total days (see i	nstructions)		16.26	8.
00	Sum of lines 7 and 8	,		18.45	9.
. 00	Allowable disproportionate share percentage (see instruc	tions)		3.81	10.
. 00	Disproportionate share adjustment (see instructions)			119, 116	11.
. 00	Total prospective capital payments (see instructions)			3, 361, 174	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
	Program inpatient routine capital cost (see instructions	)		0	1.
	Program inpatient ancillary capital cost (see instructions			0	2.
	Total inpatient program capital cost (line 1 plus line 2	-		0	
	Capital cost payment factor (see instructions)	)		0	4.
	Total inpatient program capital cost (line 3 x line 4)			0	
				1.00	
F	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			0	1.
00	Program inpatient capital costs for extraordinary circum	stances (see instructions)		0	2.
00	Net program inpatient capital costs (line 1 minus line 2	)		0	3.
00	Applicable exception percentage (see instructions)			0.00	4.
00	Capital cost for comparison to payments (line 3 x line 4	)		0	5.
00	Percentage adjustment for extraordinary circumstances (s	ee instructions)		0.00	6.
	Adjustment to capital minimum payment level for extraord		line 6)	0	7.
00   J	Capital minimum payment level (line 5 plus line 7)			0	8.
	Current year capital payments (from Part I, line 12, as	appl i cabl e)		0	9.
00	current year capital payments (riom fait 1, fine 12, as		less line 9)	0	
00 00 00	Current year comparison of capital minimum payment level				11.
00 00 00 00			or year	0	
00 00 00 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14)	ver capital payment (from pri	5	0	
00 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o	ver capital payment (from pri al payments (line 10 plus lin	e 11)		12.
00 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capit	ver capital payment (from pri al payments (line 10 plus lin enter the amount on this line	e 11) )	0	12. 13.
00 00 . 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capit Current year exception payment (if line 12 is positive,	ver capital payment (from pri al payments (line 10 plus lin enter the amount on this line	e 11) )	0	12. 13.
00 00 . 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capit Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level o	ver capital payment (from pri al payments (line 10 plus lin enter the amount on this line ver capital payment for the f	e 11) )	0	12. 13. 14.
00 00 . 00 . 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capit Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level o (if line 12 is negative, enter the amount on this line)	ver capital payment (from pri al payments (line 10 plus lin enter the amount on this line ver capital payment for the f e instructions)	e 11) )	0 0 0	12 13 14 15